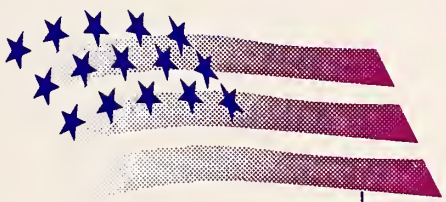
Library Edition

Information For

People With Medicare

And Those Who Serve Them



Medicare & You

The knowledge to make good decisions

Resource Kit

- Medicare & You 2000
- 1999 Guide to Health Insurance
- New health insurance now available for infants, children and teens
- Guide to Choosing a Nursing Home
- Medicare Savings for Qualified Individuals
- Medicare Preventive Services
- Medicare Worksheet for Comparing Health Plans
- www.medicare.gov
- Resources

HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

www.medicare.gov or 1-800-MEDICARE (1-800-633-4227)

The **Library Resource Kit** was designed specifically for librarians and provides useful information about the Medicare program (the federal health insurance program for the elderly and disabled). It contains tools that will assist you in serving your community and providing it with important health care information. The Health Care Financing Administration's Regional Offices are interested in on-going partnerships with you to educate your patrons about Medicare. A listing of the regional office staff, the states they serve, and projects ideas you could do together, is included in this Kit under Resources. Also included are promotional materials that your library may use. Should you have questions, you should call the regional office that covers your state.

For the most current information, the latest edition of publications, and most recent telephone numbers, please go to www.medicare.gov. If you have further questions, call the Medicare Choices helpline at 1-800-MEDICARE (1-800-633-4227).

All materials in this kit are reproducible.

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Medicare & You
The Knowledge to Make Good Decisions
Library Edition
Baltimore, Maryland

Medicare & You 2000

This handbook explains...
- **Your Medicare benefits.**
- **Your Medicare plan choices.**
- **Where you can call for help.**

Get the basics on pages 1-3.

Keep this handbook for future reference.

HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

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Sharing *Medicare & You*: Each fall, households with up to four people with Medicare will get one handbook to share. This will help save Medicare money. The other people with Medicare in these households will get a postcard. It will tell them how to get an extra handbook if they need it. If your household gets more than one handbook and you want to share copies in the future, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

If you have Employer or Union Health Coverage: See page 10 for important information.

If you are a Railroad Retiree: Call your local Railroad Retirement Board office for answers to Medicare questions. You can find your local office by calling 1-800-808-0772. More information about Medicare for Railroad Retirees is on the Internet at www.rrb.gov.

Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired), or look on the Internet at www.medicare.gov for local information on Medicare health plans in your area.

Medicare & You explains the Medicare program. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Welcome to *Medicare & You*!

This handbook gives you facts about Medicare. The first three pages are a short summary. You can read it quickly to get the basics. More details are in the rest of this handbook. **Please keep it where you can find it if you need it.**

Use this handbook to find out how Medicare works. It tells you what Medicare covers and what you can do if you have a problem.

This handbook is good (valid) from January 1, 2000 through December 31, 2000. You will get a new handbook every fall to use in the next year. That way, you will always stay up-to-date on Medicare changes.

You should know:

- ✓ Medicare gives you choices in how you get your health care (see page 10).
- ✓ Medicare does not pay for all of your health care costs. You may be able to get more health care coverage (see page 12). You may also be able to get help paying your health care costs (see page 9).
- ✓ Medicare protects you and gives you rights (see page 37).
- ✓ Medicare has a toll-free help line. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get more help with your questions about Medicare (see page 53), or look on the Internet at www.medicare.gov.

We want you to know that we will keep Medicare working for you.

Donna E. Shalala
Secretary, Health and
Human Services

Nancy-Ann Min DeParle
Administrator, Health Care
Financing Administration

How to Use This Handbook

If you are new to Medicare, or want to learn more about it...

You should read about:	On page(s)...
What Medicare covers	5-8
How to get help paying your health care costs	9
How you can get your Medicare health care coverage	11
Your Medicare rights and protections	37-42
How to sign up for Medicare Part B	43

If you want to learn about Medicare managed care plans...

You should read about:	On page(s)...
Who can join	15
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How to join	18-19
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If you have health coverage through an employer or union group plan...

You should read about:	On page(s)...
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If you need home health, hospice, mental health, or skilled nursing care...

You should read about:	On page(s)...
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What's New in *Medicare & You* 2000?

A toll-free line for help with your Medicare questions, see page 53.
A new home health notice, see page 40.
Comparing nursing homes on the Internet, see page 51.
Prostate cancer screening, see page 7.

Note: Terms in red are defined on pages 54-55.

A Quick Look at Medicare

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some disabled people under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Medicare has two parts

Part A (Hospital Insurance, see page 4.)

Most people do not have to pay for Part A.

Part B (Medical Insurance, see page 4.)

Most people pay monthly for Part B.

You may have choices in how you get your health care.

- **The Original Medicare Plan** - This plan is available everywhere in the United States (see page 11). It is the way most people get their Medicare Part A and Part B health care. You may go to any doctor, specialist, or hospital that accepts Medicare. You pay your share, and Medicare pays its share. Some things are not covered, like prescription drugs.
- **Medicare Managed Care Plans** - These are health care choices in some areas of the country (see page 15). In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare covers some tests and shots that can help you stay healthy (see page 7).

You can get help with your Medicare questions (see page 53).

What are Part A and Part B?

PART A (HOSPITAL INSURANCE)

Helps Pay For: Care in hospitals, skilled nursing facilities, hospice, and some home health care. (See page 5.)

Cost: Most people do not have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working.

For More Information:

Call your Fiscal Intermediary about bills and services (see pages 27-28). Your Fiscal Intermediary handles your Medicare Part A bills.

If you (or your spouse) did not pay Medicare taxes while you worked, you may be able to get Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card. It will show "Part A (Hospital Insurance)" on the lower left corner of the card (see page 11). You can also call your local Social Security office, or call Social Security at 1-800-772-1213.

PART B (MEDICAL INSURANCE)

Helps Pay For: Doctors, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health services. Part B helps pay for covered doctor services that are medically necessary. (See pages 6-8.)

For More Information:

Call your Medicare Carrier about bills and services (see pages 23-24). Your Medicare Carrier handles your Medicare Part B bills.

Cost: You pay the Medicare Part B premium of $45.50* per month. This is the 1999 amount and may change January 1, 2000. In some cases, this amount may be higher if you did not choose Part B when you first became eligible. **The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it.** See page 43 for more Part B enrollment information.

Enrolling in Part B is your choice. If you choose to have Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. If you do not get any of the above payments, Medicare sends you a bill for your Part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you have not received your bill by the 10th, call Social Security at 1-800-772-1213.

* New Part B premium amount will be available by January 1, 2000.

Medicare Part A (Hospital Insurance) Covers:	What You Pay in 1999* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies. This does not include private duty nursing, a television or telephone in your room, or a private room, unless medically necessary. Inpatient mental health care coverage in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period you pay:** • A total of $768 for a hospital stay of 1-60 days. • $192 per day for days 61-90 of a hospital stay. • $384 per day for days 91-150 of a hospital stay. (See Reserve Days on page 55.) • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care:** Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay). For more information on SNFs and long-term care (see pages 40 and 50).	**For each benefit period you pay:** • Nothing for the first 20 days. • Up to $96 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary. This is the company that pays Medicare Part A bills (see pages 27-28).
Home Health Care:** Part-time skilled nursing care, physical therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services (see pages 40 and 50).	**You pay:** • Nothing for home health care services. • 20% of approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see pages 29-30).
Hospice Care:** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	**You pay:** • A copayment of up to $5 for outpatient prescription drugs and a $5 per day copayment for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The copayment can change depending on where you live. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see pages 29-30).
Blood: Given at a hospital or skilled nursing facility during a covered stay.	**You pay:** • For the first 3 pints of blood.

* New Part A and B amounts will be available by January 1, 2000.

** You must meet certain conditions in order for Medicare to cover these services.

If you have general questions about Medicare Part A, call your Fiscal Intermediary. This is the company that pays Medicare Part A bills (see pages 27-28).

Medicare Part B (Medical Insurance) Covers:	What You Pay in 1999* in the Original Medicare Plan
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers outpatient physical and occupational therapy including speech-language therapy, and mental health services.	**You pay:** • $100 deductible (pay once per calendar year). • 20% of approved amount after the deductible, except in the outpatient setting. (See question 12 on page 47.) • 20% of $1,500 for all outpatient physical and speech therapy services and 20% of $1,500 for all outpatient occupational therapy services. You pay all charges above $1,500. **(Hospital outpatient therapy services do not count towards the $1,500 limits.)** • 50% for most outpatient mental health.
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**You pay:** • Nothing for services.
Home Health Care:** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare covered home health care, and other supplies and services.	**You pay:** • Nothing for services. • 20% of approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**You pay:** • 20% of the charged amount (after the deductible). During the year 2000, this will change to a set copayment amount.
Blood: Pints of blood needed as an outpatient, or as part of a Part B covered service.	**You pay:** • For the first 3 pints of blood, then 20% of the approved amount for additional pints of blood (after the deductible).

* New Part A & B amounts will be available by January 1, 2000.

** You must meet certain conditions in order for Medicare to cover these services.

Note: Actual amounts you must pay are higher if the doctor does not accept assignment (see page 47). If you have general questions about your Medicare Part B coverage, call your Medicare Carrier. This is the company that pays Medicare Part B bills (see pages 23-24).

Medicare Part B Covered Preventive Services	Who is covered...	What you pay...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare approved amount after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every year. • Flexible Sigmoidoscopy - Once every four years. • Colonoscopy - Once every two years if you are high risk for cancer of the colon. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare approved amount after the yearly Part B deductible.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare approved amount after the yearly Part B deductible.
Mammogram Screening: Once every year.	All women with Medicare age 40 and older.	20% of the Medicare approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once every year if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding three years.	All women with Medicare.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare approved amount with no Part B deductible.
Prostate Cancer Screening: Starting January 1, 2000 • Digital Rectal Examination - Once every year. • Prostate Specific Antigen (PSA) Test - Once every year.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare approved amount after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Vaccinations: • Flu Shot - Once every year. • Pneumonia Shot - One may be all you ever need, ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	No coinsurance and no Part B deductible for flu and pneumonia shots if the doctor accepts assignment (see page 47). For Hepatitis B shots, 20% of the Medicare approved amount after the Part B deductible.

Part B also helps pay for:

- Ambulance services (limited coverage).
- Artificial limbs and eyes.
- Braces - arm, leg, back, and neck.
- Chiropractic services (limited).
- Emergency care.
- Eyeglasses - one pair after cataract surgery with an intraocular lens.
- Kidney dialysis and kidney transplants.
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited).
- Preventive services (see page 7).
- Prosthetic devices, including breast prothesis after mastectomy.
- Services of practitioners such as clinical psychologists, and social workers, and nurse practitioners.
- Transplants - heart, lung, and liver (under certain conditions).
- X-rays and some other diagnostic tests.

What is not paid for by Medicare Part A and Part B in the Original Medicare Plan?

The Original Medicare Plan does not cover everything. Your out-of-pocket costs for health care will include but are not limited to:

- Your monthly Part B premium ($45.50 in 1999*).
- Deductibles, coinsurance or copayments when you get health care services (see the "What You Pay" part of the charts on pages 5-7).
- Outpatient prescription drugs (with only a few exceptions).
- Routine or yearly physical exams.
- Vaccinations except as listed on page 7.
- Orthopedic shoes.
- Custodial care (help with bathing, dressing, toileting, and eating) at home or in a nursing home.
- Most dental care and dentures.
- Routine foot care.
- Hearing aids.
- Routine eye care.
- Health care you get while traveling outside of the United States (except under limited circumstances).
- Cosmetic surgery.

Outpatient physical and occupational therapy services, including speech-language therapy except for those you get in hospital outpatient departments, have limits for each calendar year. The Original Medicare Plan does pay for some preventive care, but not all of it (see page 7).

You may be able to get help to cover the costs Medicare does not cover (see page 12). You may be able to join a Medicare managed care plan and get extra benefits (see pages 15-20).

* New Part A and B amounts will be available by January 1, 2000.

How can I get help to pay health care costs?

These programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

If you cannot afford to pay your Medicare premiums and other costs, you may be able to get help from your State. You may qualify for a Medicare assistance program as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Beneficiary (SLMB), or Qualifying Individual (QI).

These programs are for certain people who are entitled to Medicare and have a low income. They may pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance. To qualify, you must have Part A (Hospital Insurance), a limited income (see below), and your assets, such as bank accounts, stocks, and bonds must not be more than $4,000 for a single person, or $6,000 for a couple.

If you are not sure if you have Part A, look on your red, white, and blue Medicare card. It will show "Part A (Hospital Insurance)" on the lower left corner of the card, or call Social Security toll-free at 1-800-772-1213.

New Health Insurance For Children under Age 19

A new Children's Health Insurance Program is available in your State. Call 1-877-KIDS-NOW (1-877-543-7669) for more details.

	1999 Monthly Income Limit*		
	Individual	Couple	Program Pays Medicare's
QMB	$707	$942	Premiums, deductibles, and coinsurance
SLMB	$844	$1,126	Monthly Part B premium
QI-1	$947	$1,265	Monthly Part B premium
QI-2	$1,222	$1,633	A small part of the monthly Part B premium

For more information about these programs, call the medical assistance office in your area (see page 34). If you need further assistance, please call 1-800-MEDICARE (1-800-633-4227). Someone there will help you find the telephone number in your State.

*Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will change slightly in 2000, and new limits will be available by April 1, 2000.

How You Get Your Health Care is Important

Do you know what health care coverage you have? If not, you should find out. Medicare may not be the only source of health care coverage you can get. You might be able to get health care coverage or assistance that may lower your out-of-pocket costs or give you more benefits than Medicare does.

If you or your spouse still work or are retired, you may be able to get employer or union health care coverage:

- Call the employer or union to find out if you can get health care coverage based on your or your spouse's past or present employment.
- If you can get this coverage, ask your benefit administrator to help you compare their costs and benefits to Medicare's.

Caution: If you already have employer or union coverage, talk to your employer or union before you sign up for a Medicare health plan. You may not be able to get your coverage back.

If you are a veteran or a military retiree, you may be entitled to medical benefits:

- If you are a veteran, call the U.S. Department of Veteran Affairs at 1-800-827-1000. If you are retired from the military, you may also call the Department of Defense at 1-800-321-1080 for more information.

If you have a low income and limited assets, you may qualify for help paying your health care costs:

- See page 9 to see if you qualify for help in paying your health care costs. You may also call the medical assistance office in your State (see page 34).

Whether you qualify for employer or union, military, or Medicare health care coverage, you should learn about all of the different ways you may be able to get your health care. What you choose will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you (see page 11).

What are my Medicare plan choices?

Congress created the Medicare + Choice program to let more private insurance companies offer coverage to people in Medicare. The next two sections will talk about the two most common ways you may be able to get your health care in Medicare:

1. The Original Medicare Plan (available nationwide)

2. Medicare Managed Care Plans

If you live in an area served by Medicare managed care plans, you may have other choices in how you get your Medicare health care. Read pages 15-20 to see if you qualify.

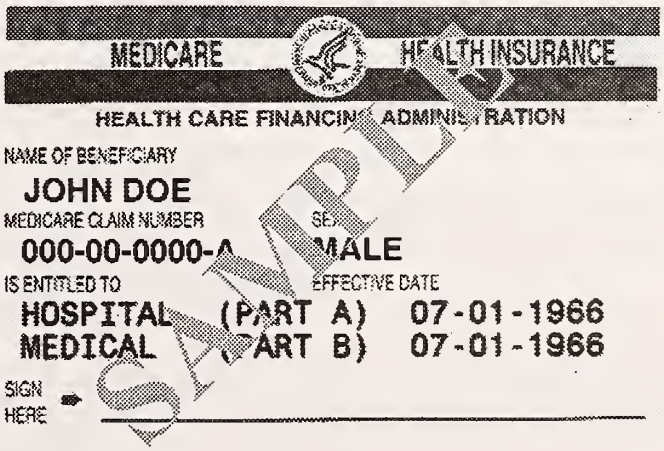
No matter how you get your Medicare health care, you are still in the Medicare program.

1. The Original Medicare Plan

The Original Medicare Plan is also known as "fee-for-service." You are usually charged a fee for each health care service or supply you get. **If you are happy getting your health care this way, you do not have to change.** You will stay in the Original Medicare Plan unless you join a Medicare managed care plan.

You can tell you are in the Original Medicare Plan if:

- You use your red, white, and blue Medicare card when you get health care (see below).



In the Original Medicare Plan:

- You may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service.
- You pay the monthly Part B premium of $45.50 (in 1999), which is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. You also pay an amount for your health care each year (deductibles) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance). After you get a health care service, you get an Explanation of Medicare Benefits or a Medicare Summary Notice in the mail. These are sent by a company that handles bills for Medicare. The notice lists what was charged, what Medicare paid, and how much you must pay.

How do my out-of-pocket costs vary?

Your costs depend on:

- Whether your doctor or supplier agrees to accept what Medicare pays (see question 12 on page 47).
- How often you need health care.
- What type of health care you need.
- Whether you get health care while traveling outside of the United States.
- Whether you choose to pay for services or supplies not covered by Medicare (see "You are protected from unexpected bills" on page 39).

To help cover the costs Medicare does not cover:

- Keep or get employer or union health coverage (see page 10), or
- Buy a Medicare Supplemental Insurance (Medigap) policy (see page 13), or
- Check if you qualify for help from your State (see page 9).

For more information on the Original Medicare Plan, see questions 10-12 on pages 46-47.

What types of private insurance supplement Medicare?

There are many types of private health coverage that pay for some or all of the health care costs not covered by Medicare. All of these types are sometimes called "supplemental coverage." These include:

- Employee Coverage* (from an employer or union);
- Retiree Coverage* (from a former employer or union); and
- Medigap Insurance (from a private company or group).

What is Medigap?

A "Medigap" policy fills gaps in Original Medicare Plan coverage. Medigap insurance must follow Federal and State laws. These laws protect you. All Medigap policies are clearly marked "Medicare Supplemental Insurance." For the rest of this book, Medicare Supplemental Insurance policies will be called Medigap.

In most states, a Medigap policy must be one of ten standardized policies to help you compare them easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT policies usually cost less because you must use certain hospitals and doctors. In an emergency, you may use any doctor or hospital.

If you are in a Medicare managed care plan, or if you are covered by Medicaid, you do not need a Medigap policy. Generally, it is not legal for anyone to sell you one in these cases.

When do most people first buy a Medigap policy?

For six months after the first day of the month in which you are age 65 or older and first join Medicare Part B, you have the right to buy the Medigap policy of your choice. During this open enrollment period, the insurance company cannot deny you insurance coverage or change the price of a policy because of past or current health problems. Once you enroll in Part B, the six month Medigap open enrollment period starts and cannot be changed.

*If you drop your employer or union based group health coverage, you probably won't be able to get it back. Call your employer's or union's benefit administrator for more information.

Important ▸

Except as described below, if you do not buy a Medigap policy during your open enrollment period you may not be able to buy the one you want, or you may be charged more for the policy. If you drop your Medigap policy, you may not be able to get it back. There are certain situations however, where you may have the right to get a Medigap policy after your open enrollment period. In these cases, the insurance company can not deny you coverage, or change the price of a policy because of past or present health problems. For example:

- You lose your health coverage (through no fault of your own) under a Medicare managed care plan, Medigap or Medicare SELECT policy, or employer coverage, or
- You join a Medicare managed care plan for the first time and within one year of joining, you decide you want to leave managed care. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to get the same policy back.

To find out if these rights apply to your situation, call 1-800-MEDICARE (1-800-633-4227). You can talk to a customer service representative and order a pamphlet called *Medicare Supplemental Insurance (Medigap) Policies and Protections*. To get these protections, you must apply for a Medigap policy within **63 calendar days** after your coverage ends.

For More Information about Medigap Policies ▸

- Call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of the *Guide to Health Insurance for People with Medicare*. This guide gives information on buying a Medigap policy, using Medigap insurance and other kinds of health insurance, and your rights and protections. The guide is also available on the Internet at www.medicare.gov.
- Contact your State Health Insurance Assistance Program (see page 25). Volunteer counselors can help you understand and compare your Medigap choices. This service is free.

2. Medicare Managed Care Plans

Medicare managed care plans are offered by private companies. They are a different way to get your Medicare health care. Many people with Medicare have managed care as an option. A company can decide that a plan will be available to everyone with Medicare in a State, or be open only in certain counties. The company may also choose to offer more than one plan in an area, with different benefits and costs. **Each year, managed care companies can decide to join or leave Medicare.**

Some people in Medicare have already joined a managed care plan. If you are in a Medicare managed care plan, you should have a membership card with the name of the plan on it. If you are not sure if you are in a Medicare managed care plan, you can call the number listed on your membership card, or call your local Social Security office, or call Social Security at 1-800-772-1213.

If you join a Medicare managed care plan:

- You are still in the Medicare program.
- You must continue to pay the monthly Part B premium of $45.50 (in 1999).
- You will keep your Medicare rights and protections (see pages 37-42).
- You still get all your regular Medicare covered services (see pages 5-8).

Can I join a Medicare managed care plan?

You can join a Medicare managed care plan if:

- You have both Part A (Hospital Insurance) and Part B (Medical Insurance).
- You do not have End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant). However, if you have End-Stage Renal Disease and are already in a Medicare managed care plan, you can stay in your plan. Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare managed care plans.
- You live in the service area of the plan. The service area is where the plan accepts members and where you get services from the plan. In general, if you move out of the plan's service area you cannot stay in the plan. You must disenroll and you will then be covered under the Original Medicare Plan. Or, you can choose to join another Medicare managed care plan, if one is available in your new area.

How does managed care work?

- In most managed care plans, you can only go to certain doctors and hospitals who have agreed to treat members of the plan. Generally, you can only see a specialist (like a cardiologist) when you get a referral (see page 49), which means your plan doctor says it is OK to go.
- You can often get extra benefits, like outpatient prescription drugs.
- Some managed care plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who are not on the plan's list. Most of the time this option costs you more, and gives you more choices.

How do my out-of-pocket costs vary?

Your costs depend on:

- Whether the plan charges a premium in addition to the monthly Part B premium ($45.50 in 1999).
- How much the plan charges per visit, such as a $5 or $10 copayment every time you see your doctor (in place of the 20% coinsurance charged in Original Medicare).
- The type of health care you need and how often you get it.
- How much the plan charges for extra benefits.
- Whether you get health care outside the service area of the plan (except in an emergency, see page 49).

What do I need to think about when I compare managed care plans?

- **Cost:** What will my out-of-pocket costs be?
- **Doctor Choice:** Which doctors are in the plan? Can I see the doctor(s) I want to see?
- **Benefits:** Will I get extra services and items, like outpatient prescription drugs?
- **Convenience:** Where are the offices of the plan's doctors and what are their hours? (Generally, you cannot get health care outside of a plan's service area.)
- **Quality:** How well does the plan keep its members healthy or treat them when they are sick?

TO CHOOSE A MEDICARE MANAGED CARE PLAN, YOU NEED TO KNOW...	TO FIND OUT...
Is the plan offered where I live, what does it cost, and what extra benefits are covered?	Call 1-800-MEDICARE (1-800-633-4227) and ask for a free, up-to-date list of all the plans offered where you live, with detailed information about extra benefits and costs. OR Look at Medicare Compare on the Internet at www.medicare.gov. If you do not have a personal computer, your local library or senior center may be able to help you. THEN Call any plan you may be interested in. They can tell you if the plan is offered where you live and can send you up-to-date, detailed information about their extra benefits and costs.
What doctors or hospitals belong to that plan?	Call your doctor to ask if he or she is in the plan and would continue to see you if you joined the plan.
How does the plan rate in quality?	Call 1-800-MEDICARE (1-800-633-4227) and ask for quality and satisfaction information. It will be mailed free of charge. OR Look at Medicare Compare on the Internet on www.medicare.gov. If you do not have a personal computer, your local library or senior center may be able to help you.
How does the plan respond to grievances?	Call the plan. Beginning on February 1, 2000, you can ask any managed care plan for information about any grievances and appeals that were made (see page 38).
Who can help me compare plans?	Call your State Health Insurance Assistance Program (see page 25). Volunteer counselors can help you compare the managed care plans available to you.

How do I get information to help me decide whether to join a managed care plan?

You will need to get up-to-date information about each plan you are interested in before you make any decision about joining one of them (see page 20). Plans can join or leave Medicare, and costs and extra benefits can change.

Before you join a Medicare managed care plan, keep in mind that...

- Managed care plans are offered by private companies. Each year they can change the extra benefits they offer and how much they charge. The plans must tell you about these changes in advance.
- When managed care plans sign a contract with Medicare, they agree to stay for at least one calendar year. Each year, they make a business decision to stay or leave the Medicare program.
- Doctors can join or leave managed care plans at any time.
- Managed care plans may charge an extra monthly premium, in addition to your monthly Part B premium.
- Some managed care companies limit the number of members in their plans. These plans may not accept new members all of the time. A company can tell you if a plan has reached its limit, or if it is still signing up new members.

How do I join a managed care plan?

To join a plan:

1. Call the plan and request an enrollment form.
2. Fill out the form and mail it to the plan.
3. You will get a letter telling you when your coverage begins.

Note: During the month of November, Medicare managed care plans (with some exceptions) must accept new members. If you join in November, your coverage begins on January 1, 2000.

You can't join more than one managed care plan at the same time. If you try to join more than one managed care plan with the same effective dates, you will end up in the same health plan that you started out with (either a managed care plan or the Original Medicare Plan), and you will keep getting your health care through that plan.

If you join a managed care plan and change your mind, you must call the plan you joined before the date your coverage begins. Tell them you want to cancel. Depending on when you call, the plan may ask you to fill out a form to leave. If the plan does not ask you to, you do not have to fill out or send any form to leave this plan. After you cancel, you can stay with your current plan (including Original Medicare Plan) or join a new managed care plan.

How do I leave a managed care plan?

In the year 2000, you may leave a plan at any time for any reason. Write to the plan or the Social Security Administration and tell them you want to leave. When you leave a plan you are automatically returned to the Original Medicare Plan (unless you join another Medicare managed care plan). In most cases, your new coverage starts the month after you leave the plan.

Starting in 2002, you may only be able to leave a plan at certain times. Call 1-800-MEDICARE (1-800-633-4227) for more information.

Can I keep my Medigap policy if I join a managed care plan?

If you join a Medicare managed care plan, you may keep your Medigap policy (but you can't use it unless you return to the Original Medicare Plan). If you drop your Medigap policy, you may have the right to get another Medigap policy later if:

- You lose your Medicare managed care plan coverage (through no fault of your own), or
- You join a Medicare managed care plan for the first time, and within one year of joining, you decide you want to leave managed care. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to get the same policy back.

For more information about Medigap policies, see pages 13-14.

To find out if these rights apply to your situation, call 1-800-MEDICARE (1-800-633-4227). You can talk to a customer service representative and order a pamphlet called *Medicare Supplemental Insurance (Medigap) Policies and Protections*. To get these protections, you must apply for a Medigap policy **within 63 calendar days** after your coverage ends.

For More Information About How You Get Your Health Care ▸

1. See questions 13-18 on pages 48-49.
2. Call **1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048** for the hearing and speech impaired) and ask for:
   - Detailed plan information - a list of benefits and costs of the plans available where you live.
   - Quality information for the plans available where you live.
   - The *Worksheet for Comparing Medicare Health Plans* (to help you compare plans).
   - The *Guide to Health Insurance for People with Medicare*. This guide gives information on buying a Medigap Policy, using Medigap insurance and other kinds of health insurance, and your rights and protections. The guide is also available on the Internet at www.medicare.gov.

For More Information About Other Plans ▸

You may have heard about Medicare Medical Savings Accounts and Private Fee-for-Service plans. At the time this handbook was printed, no private insurance companies were offering these types of plans to people with Medicare. To find out if any of these plans have become available in your area or to get pamphlets about these plans, call **1-800-MEDICARE (1-800-633-4227)**, and ask for:

- *Your Guide to Medicare Medical Savings Accounts.*
- *Your Guide to Private Fee-for-Service Plans.*

Who to call for help with your Medicare questions

Medicare works with different groups who can help you with your Medicare questions. On the next 14 pages are the phone numbers you may call for help. If there is a special number for your State, it will be listed. If you are in a Medicare managed care plan, you should call your plan with questions about bills, health services, and appeals.

Call...	If you have questions about...	See page...
Social Security Administration (SSA)	Changing your address, Medicare Part A or Part B, lost Medicare card, and Social Security benefits	22
State Health Insurance Assistance Program	Medicare Supplemental Insurance (Medigap) Policies, Medicare health plan choices, and help with filing an appeal	25
Medicare Carrier	Part B bills and services, and fraud and abuse	23-24
Durable Medical Equipment Regional Carrier (DMERC)	Bills for durable medical equipment and a list of approved suppliers of this equipment	26
Fiscal Intermediary (FI)	Part A bills and services, hospital care, skilled nursing care, and fraud and abuse	27-28
Health Care Financing Administration (HCFA) Regional Office	Local seminars and health fairs on your Medicare health plan choices, and reporting a complaint	35
1-800-MEDICARE Helpline	General Medicare information, ordering Medicare publications, and information about health plans	22
Office for Civil Rights	Discrimination	22
Office of the Inspector General	Reporting fraud and abuse	22
Peer Review Organization (PRO)	Complaints about quality of care, and filing an appeal or compaint	31-32
Regional Home Health Intermediary (RHHI)	Home health care, hospice care, and fraud and abuse	29-30
State Insurance Department	Medicare Supplemental Insurance (Medigap) Policies available in your area	33
State Medical Assistance Office	Low-income programs to help pay medical bills	34
Railroad Retirement Board (Railroad Retirement beneficiaries only)	RRB - Medicare bills and coverage	22
	RRB benefits, lost Medicare card, Medicare premium amounts, enrolling in Medicare	22

1-800-MEDICARE Helpline

Call about:

- TTY/TDD and local phone numbers
- General Medicare information
- Ordering Medicare publications
- Information about health plans

All States

1-800-MEDICARE
TTY: 1-877-486-2048

Office of the Inspector General

Call about:

- Reporting fraud and abuse

All States

1-800-447-8477
TTY: 1-800-377-4950

Railroad Retirement Board

Call about:

- Lost RRB Medicare card, address change
- Part A bills and services (Fiscal Intermediary)
- Part B bills and services (United HealthCare)

RRB Beneficiaries Only

1-800-808-0772 (RRB)
see pages 27-28
1-800-833-4455 (UHC)

Social Security Administration

Call about:

- Changing your address
- Medicare Part A or Part B
- Lost Medicare card

All States

1-800-772-1213
TTY: 1-800-325-0778

Office for Civil Rights

Call about:

- Discrimination

All States

1-800-368-1019

Medicare Carriers: Call about Part B bills and services, and fraud and abuse.

Alabama
Blue Cross & Blue Shield,
1(800)292-8855

Alaska
Noridian Mutual Insurance Company,
1(800)444-4606

American Samoa
Noridian Mutual Insurance Company,
1(800)444-4606

Arizona
Noridian Mutual Insurance Company,
1(800)444-4606

Arkansas
Blue Cross & Blue Shield Of Arkansas,
1(800)482-5525 in-state calls only

California
Transamerica Occidental Life,
1(800)675-2266 Counties of Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, Santa Barbara
National Heritage Insurance Co,
1(800)952-8627 Rest of state

Colorado
Noridian Mutual Insurance Company,
1(800)332-6681

Connecticut
United Health Care,
1(800)982-6819 in-state calls only

Delaware
Trailblazers,
1(800)444-4606 Also services Fairfax and Alexandria Counties, Arlington, VA

Florida
Blue Cross & Blue Shield,
1(800)333-7586 in-state calls only

Georgia
Cahaba Govt Benefit Adminstr.,
1(800)727-0827

Guam
Noridian Mutual Insurance Company,
1(800)444-4606

Hawaii
Noridian Mutual Insurance Company,
1(800)444-4606

Idaho
Cigna Medicare,
1(800)342-8900 in-state calls only

Illinois
Wisconsin Physicians Service,
1(800)642-6930

Indiana
Adminastar Federal,
1(800)622-4792

Iowa
Noridian Mutual Insurance Company,
1(800)532-1285

Kansas
Blue Cross & Blue Shield Of Kansas,
1(800)633-1113

Kentucky
Adminastar Federal,
1(800)999-7608

Louisiana
Louisiana Medicare - Part B,
1(800)462-9666 in-state calls only

Maine
National Heritage Insurance Co,
1(800)882-1228

Maryland
Trailblazers,
1(800)444-4606 Also services Fairfax and Alexandria Counties, Arlington, VA

Massachusetts
National Heritage Insurance Co,
1(800)882-1228

Michigan
Wisconsin Physicians Service,
1(800)482-4045

Minnesota
United Health Care,
1(800)352-2762 in-state calls only

Mississippi
United Health Care,
1(800)682-5417 in-state calls only

Missouri
Blue Cross And Blue Shield Of Arkansas,
1(800)392-3070 St. Louis City and County, Jefferson County, and area 99
Blue Cross & Blue Shield,
1(800)432-0216 out-of-state calls only
1(800)892-5900 in-state calls only

Montana
Blue Cross & Blue Shield Of Montana,
1(800)332-6146 in-state calls only

Medicare Carriers: Call about Part B bills and services, and fraud and abuse.

Nebraska
Blue Cross & Blue Shield,
1(800)633-1113

Nevada
Noridian Mutual Insurance Company,
1(800)444-4606

New Hampshire
National Heritage Insurance Co,
1(800)882-1228

New Jersey
Empire Medicare Services - New Jersey Operations,
1(800)462-9306

New Mexico
Blue Cross And Blue Shield Of Arkansas,
1(800)423-2925

New York
Blue Cross & Blue Shield,
1(800)252-6550 Services upstate NY
Empire Medicare Services,
1(800)442-8430 Services downstate NY
Group Health Inc.,
1(800)632-5572 Queens county only

North Carolina
Cigna Medicare,
1(800)672-3071 in-state calls only

North Dakota
Noridian Mutual Insurance Company,
1(800)247-2267

Northern Mariana Islands
Noridian Mutual Insurance Company,
1(800)444-4606

Ohio
Nationwide Mutual Insurance Co,
1(800)848-0106

Oklahoma
Blue Cross And Blue Shield Of Arkansas,
1(800)522-9079

Oregon
Noridian Mutual Insurance Company,
1(800)444-4606

Pennsylvania
Xact Medicare Services,
1(800)382-1274 in-state calls only

Puerto Rico
Triple S Inc.,
1(800)981-7015 in-state calls only

Rhode Island
Blue Cross & Blue Shield Of Rhode Island,
1(800)662-5170

South Carolina
Palmetto Government Benefits Administration,
1(800)868-2522

South Dakota
Noridian Mutual Insurance Company,
1(800)437-4762

Tennessee
Cigna Medicare,
1(800)342-8900 in-state calls only

Texas
Blue Cross & Blue Shield,
1(800)442-2620

Utah
Blue Cross & Blue Shield,
1(800)426-3477

Vermont
National Heritage Insurance Co,
1(800)882-1228

Virgin Islands
Triple S,
1(800)474-7448 in-state calls only

Virginia
Trailblazers,
1(800)444-4606 Also services Fairfax and Alexandria Counties, Arlington, VA
United Healthcare/Travelers. Ins.,
1(800)552-3423 in-state calls only

Washington
Noridian Mutual Insurance Company,
1(800)444-4606

Washington D.C.
Trailblazers,
1(800)444-4606 Also services Fairfax and Alexandria Counties, Arlington, VA

West Virginia
Nationwide Mutual Insurance Co,
1(800)848-0106

Wisconsin
Wisconsin Physicians Service,
1(800)944-0051 in-state calls only

Wyoming
Noridian Mutual Insurance Company,
1(800)442-2371

State Health Insurance Assistance Program: Call about Medicare Supplemental Insurance (Medigap) Policies, Medicare health plan choices, and help with filing an appeal.

Alabama
1(800)243-5463
in-state calls only

Alaska
1(800)478-6065
in-state calls only

American Samoa
1(808)586-7299
Government of American Samoa

Arizona
1(800)432-4040

Arkansas
1(800)224-6330

California
1(800)434-0222 or call 800-510-2020 in-state calls only

Colorado
1(800)544-9181
in-state calls only

Connecticut
1(800)994-9422
in-state calls only

Delaware
1(800)336-9500
in-state calls only

Florida
1(800)963-5337
in-state calls only

Georgia
1(800)669-8387
in-state calls only

Guam
1(808)586-7299

Hawaii
1(808)586-7299

Idaho
1(800)247-4422
in-state calls only

Illinois
1(800)548-9034
in-state calls only

Indiana
1(800)452-4800

Iowa
1(800)351-4664

Kansas
1(800)860-5260
in-state calls only

Kentucky
1(502)564-7372

Louisiana
1(800)259-5301
in-state calls only

Maine
1(800)750-5353

Maryland
1(800)243-3425
in-state calls only

Massachusetts
1(800)882-2003
in-state calls only

Michigan
1(800)803-7174

Minnesota
1(800)333-2433

Mississippi
1(800)948-3090

Missouri
1(800)390-3330

Montana
1(800)332-2272
in-state calls only

Nebraska
1(800)234-7119

Nevada
1(800)307-4444

New Hampshire
1(800)852-3388
in-state calls only

New Jersey
1(800)792-8820
in-state calls only

New Mexico
1(800)432-2080
in-state calls only

New York
1(800)333-4114

North Carolina
1(800)443-9354
in-state calls only

North Dakota
1(800)247-0560
in-state calls only

Northern Mariana Islands
1(808)586-7299
Government of American Samoa

Ohio
1(800)686-1578
in-state calls only

Oklahoma
1(800)763-2828
in-state calls only

Oregon
1(800)722-4134

Pennsylvania
1(800)783-7067

Puerto Rico
1(877)725-4300
in-state calls only

Rhode Island
1(800)322-2880
in-state calls only

South Carolina
1(800)868-9095
in-state calls only

South Dakota
1(800)822-8804

Tennessee
1(800)525-2816

Texas
1(800)252-9240

Utah
1(800)541-7735
in-state calls only

Vermont
1(800)642-5119
in-state calls only
1(802)748-5182 out-of-state calls only

Virgin Islands
1(340)778-6311
X2338

Virginia
1(800)552-3402

Washington
1(800)397-4422
in-state calls only

Washington D.C.
1(202)676-3900

West Virginia
1(877)987-4463

Wisconsin
1(800)242-1060

Wyoming
1(800)856-4398

Durable Medical Equipment Regional Carrier (DMERC): Call about bills for durable medical equipment and a list of approved suppliers of this equipment.

If you live in:	Your DMERC is:
Illinois Indiana Maryland Michigan Minnesota Ohio Virginia Washington D.C. West Virginia Wisconsin	Administar Federal 1(800)270-2313

If you live in:	Your DMERC is:
Alaska American Samoa Arizona California Guam Hawaii Idaho Iowa Kansas Missouri Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming	Cigna Medicare 1(800)899-7095

If you live in:	Your DMERC is:
Alabama Arkansas Colorado Florida Georgia Kentucky Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands	Palmetto Government Benefits 1(800)213-5452

If you live in:	Your DMERC is:
Connecticut Delaware Maine Massachusetts New Hampshire New Jersey New York Pennsylvania Rhode Island Vermont	United Health Care - Region A 1(800)842-2052

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse.

Alabama
Mutual Of Omaha,
1(402)351-2860

Alaska
Premera Blue Cross,
1(425)670-1010

American Samoa
Hawaii Medical Service,
1(808)948-6247

Arizona
Blue Cross Of Arizona,
1(602)864-4298

Arkansas
Blue Cross & Blue Shield,
1(501)378-2173

California
Blue Cross Of California,
1(805)383-2038

Colorado
Blue Cross & Blue Shield,
1(800)442-2620

Connecticut
United Health Care,
1(203)639-3222

Delaware
Empire Medicare Services,
1(800)442-8430

Florida
Blue Cross & Blue Shield,
1(904)355-8899

Georgia
Blue Cross & Blue Shield,
1(706)322-4082

Guam
Hawaii Medical Service,
1(808)948-6247

Hawaii
Hawaii Medical Service,
1(808)948-6247

Idaho
Blue Cross Blue Shield/Oregon,
1(503)721-7000

Illinois
Adminastar Federal,
1(312)938-6266

Indiana
Adminastar Federal,
1(800)622-4792

Iowa
Wellmark Blue Cross Blue Shield Of Iowa,
1(712)279-8650

Kansas
Blue Cross & Blue Shield - Part A,
1(800)445-7170

Kentucky
Adminastar Federal,
1(800)999-7608

Louisiana
Trispan Health Svcs. /Medicare,
1(800)932-7644

Maine
Assoc. Hospital Svc. Of Maine,
1(888)896-4997

Maryland
Trailblazers,
1(800)444-4606

Massachusetts
Assoc. Hospital Svc. Of Maine,
1(888)896-4997

Michigan
Wisconsin United Government Services,
1(313)225-8317

Minnesota
Blue Cross & Blue Shield,
1(800)382-2000

Mississippi
Trispan Health Svcs. /Medicare,
1(800)932-7644

Missouri
Trispan Health Svcs. /Medicare,
1(800)932-7644

Montana
Blue Cross & Blue Shield,
1(800)447-7828X4086

Nebraska
Blue Cross & Blue Shield,
1(402)390-1850

Nevada
Blue Cross Of California,
1(805)383-2038

Fiscal Intermediary: Call about Part A bills and services, hospital care, skilled nursing care, and fraud and abuse.

New Hampshire
New Hampshire/Vermont Health Service,
1(603)695-7204

New Jersey
Horizon Blue Cross & Blue Shield Of New Jersey,
1(973)456-2112

New Mexico
Blue Cross & Blue Shield,
1(800)442-2620

New York
Empire Medicare Services,
1(800)442-8430

North Carolina
Blue Cross & Blue Shield,
1(800)685-1512 in-state calls only

North Dakota
Noridian Mutual Insurance Company,
1(800)247-2267

Northern Mariana Islands
Hawaii Medical Service,
1(808)948-6247

Ohio
Adminastar Federal,
1(513)852-4314

Oklahoma
Blue Cross And Blue Shield,
1(918)560-3367

Oregon
Blue Cross Blue Shield/Oregon,
1(503)721-7000

Pennsylvania
Veritus Medicare Services,
1(800)853-1419

Puerto Rico
Cooperativa De Seguros De Vida,
1(800)986-5656 in-state calls only

Rhode Island
Blue Cross & Blue Shield Of Rhode Island,
1(800)662-5170

South Carolina
Blue Cross And Blue Shield Of South Carolina,
1(803)788-4660

South Dakota
Wellmark,
1(712)279-8650

Tennessee
Blue Cross & Blue Shield,
1(423)755-5955

Texas
Blue Cross & Blue Shield,
1(800)442-2620

Utah
Blue Cross & Blue Shield,
1(801)333-2410

Vermont
New Hampshire/Vermont Health Service,
1(603)695-7204

Virgin Islands
Cooperativa De Seguros De Vida,
1(800)986-5656 in-state calls only

Virginia
Blue Cross & Blue Shield,
1(540)985-3931

Washington
Premera Blue Cross,
1(425)670-1010

Washington D.C.
Mutual Of Omaha,
1(402)351-2860

West Virginia
Blue Cross & Blue Shield,
1(540)985-3931

Wisconsin
Blue Cross Blue Shield Of WI,
1(414)224-4954

Wyoming
Blue Cross & Blue Shield,
1(800)442-2376

Regional Home Health Intermediary (RHHI): Call about home health care, hospice care, and fraud and abuse.

If you live in:	Your Regional Home Health Intermediary is:
Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	Assoc. Hospital Svc Of Maine 1(888)896-4997

If you live in:	Your Regional Home Health Intermediary is:
Alaska American Samoa Arizona California Guam Hawaii Idaho Nevada Northern Mariana Islands Oregon Washington	Blue Cross Of California Medicare 1(805)383-2990

If you live in:	Your number to call about Medicare home health benefits is:
Maryland Washington D.C.	Medicare Customer Service Center 1(800)444-4606

Regional Home Health Intermediary (RHHI): Call about home health care, hospice care, and fraud and abuse.

If you live in:		Your Regional Home Health Intermediary is:
Alabama	Georgia	Palmetto Government Benefits 1(727)773-9225
Florida	Mississippi	
Arkansas	North Carolina	Palmetto Government Benefits 1(803)788-4660
Illinois	Ohio	
Indiana	Oklahoma	
Kentucky	South Carolina	
Louisiana	Tennessee	
New Mexico	Texas	

If you live in:	Your Regional Home Health Intermediary is:
Michigan Minnesota New Jersey New York Puerto Rico Virgin Islands Wisconsin	United Government Services 1(414)224-4954

If you live in:		Your Regional Home Health Intermediary is:
Colorado	North Dakota	Wellmark/Blue Cross Blue Shield Of Iowa 1(515)246-0126
Delaware	South Dakota	
Iowa	Utah	
Kansas	Virginia	
Missouri	West Virginia	
Montana	Wyoming	
Nebraska		

Peer Review Organization (PRO): Call about quality of care complaints and filing an appeal or complaint.

Alabama
Quality Assurance Foundation,
1(800)760-4550

Alaska
Pro-west,
1(800)878-7170

American Samoa
Mountain Pacific Quality Health Foundation,
1(800)524-6550

Arizona
Health Services Advisory Group Inc.,
1(800)359-9909

Arkansas
Foundation For Medical Care,
1(800)272-5528

California
California Medical Review,
1(800)841-1602

Colorado
Foundation For Medical Care,
1(800)727-7086

Connecticut
Qualidigm,
1(800)553-7590

Delaware
West Virginia Medical Institute,
1(800)422-8804 in-state calls only

Florida
Fl. Medical Quality Assurance,
1(800)844-0795

Georgia
Georgia Medical Care Foundaton,
1(800)979-7217

Guam
Mountain Pacific Quality Health Foundation,
1(800)524-6550

Hawaii
Mountain Pacific Quality Health Foundation,
1(800)524-6550

Idaho
Pro-west,
1(800)445-6941

Illinois
Il Found. For Quality Health Care,
1(800)647-8089

Indiana
Health Care Excel,
1(800)288-1499

Iowa
Iowa Foundation For Medical Care,
1(800)752-7014

Kansas
Foundation For Medical Care,
1(800)432-0407

Kentucky
Health Care Excel,
1(800)288-1499

Louisiana
Louisiana Health Care Review, Inc.,
1(800)433-4958 in-state calls only

Maine
NE Health Care Quality Foundation,
1(800)772-0151 New Hampshire,
Vermont and Maine only

Maryland
Delmarva Foundation Medic. Care,
1(800)492-5811

Massachusetts
Masspro,
1(800)252-5533 in-state calls only

Michigan
Michigan Peer Review Organizan,
1(877)787-2847

Minnesota
Stratis Health,
1(877)787-2847

Mississippi
Foundation For Medical Care,
1(800)844-0600

Missouri
Patient Care Review Foundation,
1(800)347-1016

Montana
Mountain Pacific Quality Health Foundation,
1(800)497-8232

Nebraska
Sunderbruch Corporation,
1(800)247-3004

Nevada
Healthinsight,
1(800)748-6773 or 1(800)748-6944

Peer Review Organization (PRO): Call about quality of care complaints and filing an appeal or complaint.

New Hampshire
NE Health Care Quality Foundation,
1(800)772-0151 New Hampshire, Vermont and Maine only

New Jersey
Peer Review Organization Of NJ,
1(800)624-4557 in-state calls only

New Mexico
Medical Review Association,
1(800)279-6824

New York
Ipro,
1(800)331-7767 Appeals

North Carolina
Medical Review Of North Carolina Inc.,
1(800)722-0468

North Dakota
North Dakota Health Care Revew,
1(800)472-2902 in-state calls only

Northern Mariana Islands
Mountain Pacific Quality Health Foundation,
1(800)524-6550

Ohio
Peer Review Systems, Inc.,
1(800)589-7337 in-state calls only
1(800)837-0664 out-of-state calls only

Oklahoma
Foundation For Medical Quality,
1(800)522-3414 in-state calls only

Oregon
Oregon Medical Professional,
1(800)344-4354

Pennsylvania
Kepro,
1(800)322-1914

Puerto Rico
Quality Improvement Prof. Rsrch,
1(800)981-5062 in-state calls only

Rhode Island
Rhode Island Quality Partners,
1(800)662-5028 or call 1-800-553-7590 for Connecticut

South Carolina
Carolina Medical Review,
1(800)922-3089 in-state calls only

South Dakota
Foundation For Medical Care,
1(800)658-2285

Tennessee
Foundation For Medical Care,
1(800)489-4633

Texas
Texas Medical Foundation,
1(800)725-8315

Utah
Healthinsight,
1(800)274-2290

Vermont
NE Health Care Quality Foundation,
1(800)772-0151 New Hampshire, Vermont and Maine only

Virgin Islands
V. I. Medical Institute Inc.,
1(340)778-6470

Virginia
Virginia Health Quality Ctr,
1(800)545-3814 in-state calls only

Washington
Pro-west,
1(800)445-6941

Washington D.C.
Delmarva Found. For Med. Care,
1(800)999-3362

West Virginia
West Virginia Med. Instit. Inc,
1(800)422-8804 in-state calls only

Wisconsin
Wisconsin Peer Review Organization,
1(800)362-2320

Wyoming
Mountain Pacific Quality Health Foundation,
1(800)497-8232

State Insurance Department: Call about Medicare Supplemental Insurance (Medigap) Policies available in your area.

Alabama 1(334)206-5111	**Georgia** 1(800)656-2298 in-state calls only	**Maine** 1(800)300-5000 in-state calls only	**New Hampshire** 1(800)852-3416 in-state calls only	**Pennsylvania** 1(877)881-6388 in-state calls only	**Virginia** 1(800)552-7945
Alaska 1(800)467-8725 in-state calls only	**Guam** Number Not Available	**Maryland** 1(800)492-6116	**New Jersey** 1(609)292-5363	**Puerto Rico** 1(787)722-8686	**Washington** 1(800)397-4422 in-state calls only
American Samoa 1(808)586-2790	**Hawaii** 1(808)586-2790	**Massachusetts** 1(617)521-7794	**New Mexico** 1(800)947-4722	**Rhode Island** 1(401)222-2223	**Washington D.C.** 1(202)727-8000
Arizona 1(800)325-2548 in-state calls only	**Idaho** 1(800)445-6941	**Michigan** 1(517)373-0240	**New York** 1(800)342-3736 in-state calls only	**South Carolina** 1(800)768-3467	**West Virginia** 1(800)642-9004 in-state calls only
Arkansas 1(800)852-5494	**Illinois** 1(217)782-4515	**Minnesota** 1(800)657-3602 in-state calls only	**North Carolina** 1(800)443-9354 in-state calls only	**South Dakota** 1(605)773-3563	**Wisconsin** 1(800)236-8517 in-state calls only
California 1(800)927-4357	**Indiana** 1(800)622-4461 in-state calls only	**Mississippi** 1(800)562-2957 in-state calls only	**North Dakota** 1(800)247-0560 in-state calls only	**Tennessee** 1(800)525-2816	**Wyoming** 1(800)438-5768 in-state calls only
Colorado 1(800)930-3745	**Iowa** 1(515)281-5705	**Missouri** 1(800)726-7390	**Northern Mariana Islands** 1(808)586-2790	**Texas** 1(800)252-3439	
Connecticut 1(800)203-3447	**Kansas** 1(800)432-2484 in-state calls only	**Montana** 1(800)332-6148 in-state calls only	**Ohio** 1(800)686-1526	**Utah** 1(800)439-3805 in-state calls only	
Delaware 1(800)282-8611 in-state calls only	**Kentucky** 1(800)595-6053	**Nebraska** 1(877)564-7323 in-state calls only	**Oklahoma** 1(800)522-0071 in-state calls only	**Vermont** 1(800)631-7788 in-state calls only	
Florida 1(800)342-2762 in-state calls only	**Louisiana** 1(800)259-5301 in-state calls only	**Nevada** 1(800)992-0900 in-state calls only	**Oregon** 1(800)722-4134 in-state calls only	**Virgin Islands** 1(340)774-7166	

State Medical Assistance Office: Call about low-income programs to help pay medical bills.

Alabama
1(800)362-1504

Alaska
1(800)211-7470

American Samoa
1(808)587-3521

Arizona
1(800)334-5283

Arkansas
1(800)482-8988

California
1(800)952-5253

Colorado
1(800)221-3943

Connecticut
1(800)842-1508
in-state calls only

Delaware
1(800)372-2022

Florida
1(850)488-3560

Georgia
1(800)766-4456
in-state calls only

Guam
Number Not Available

Hawaii
1(808)587-3521

Idaho
1(800)926-2588

Illinois
1(800)252-8635
in-state calls only

Indiana
1(800)433-0746
in-state calls only

Iowa
1(800)972-2017

Kansas
1(800)766-9012

Kentucky
1(800)635-2570

Louisiana
1(888)342-6207
in-state calls only

Maine
1(800)321-5557
in-state calls only

Maryland
1(800)463-3461

Massachusetts
1(800)841-2900

Michigan
1(800)292-2550 out-of-state calls only
1(800)642-3195
in-state calls only

Minnesota
1(800)366-5411

Mississippi
1(800)421-2408
in-state calls only

Missouri
1(800)392-2161

Montana
1(800)362-8312

Nebraska
1(800)430-3244
Department of Health & Human Services

Nevada
1(800)992-0900
in-state calls only

New Hampshire
1(800)852-3345
in-state calls only

New Jersey
1(800)356-1561

New Mexico
1(800)432-6217
in-state calls only

New York
1(518)486-4803

North Carolina
1(800)662-7030

North Dakota
1(800)755-2604

Northern Mariana Islands
1(808)587-3521

Ohio
1(800)324-8680

Oklahoma
1(800)522-0310
in-state calls only

Oregon
1(800)282-8096
in-state calls only

Pennsylvania
1(800)692-7462
in-state calls only

Puerto Rico
1(877)641-2004
in-state calls only

Rhode Island
1(401)222-7000

South Carolina
1(803)898-2500

South Dakota
1(800)452-7691

Tennessee
1(800)669-1851

Texas
1(800)252-8263

Utah
1(800)662-9651
in-state calls only

Vermont
1(800)250-8427
in-state calls only

Virgin Islands
1(877)641-2004
in-state calls only

Virginia
1(804)786-7933

Washington
1(800)562-3022

Washington D.C.
1(202)727-0735

West Virginia
1(304)926-1700

Wisconsin
1(800)362-3002

Wyoming
1(800)251-1269

Health Care Financing Administration (HCFA) Regional Offices: Call about local seminars and health fairs on your Medicare health plan choices, and reporting a complaint.

If you live in:	The Regional Office is in:	The phone number is:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Boston	1(617)565-1232
New Jersey, New York, Puerto Rico, Virgin Islands	New York	1(212)264-3657
Delaware, Maryland, Pennsylvania, Virginia, Washington D.C., West Virginia	Philadelphia	1(215)861-4226
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Atlanta	1(404)562-7500
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Chicago	1(312)353-7180
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Dallas	1(214)767-6401
Iowa, Kansas, Missouri, Nebraska	Kansas City	1(816)426-2866
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Denver	1(303)844-4024
American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands	San Francisco	1(415)744-3602
Alaska, Idaho, Oregon, Washington	Seattle	1(206)615-2354

You can use the space below to put any important phone numbers you call often.

NAME	PHONE NUMBER

Your Medicare Patient Rights

If you have Medicare, you have certain guaranteed rights. You have them whether you are in the Original Medicare Plan or a Medicare managed care plan.

- You have the right to get emergency care when and where you need it, without prior approval. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.
- You have the right to appeal if Medicare does not pay for a covered service you have been given, or if your doctor or hospital does not give you a service that you believe should be covered (see pages 38-39).
- You have the right to know all your treatment options from your health care provider in language that is clear to you. Medicare must give you information about what is covered and how much you have to pay. Medicare managed care plans cannot have rules that stop a doctor from telling you everything you need to know about your health care, including treatment options.
- You have the right to have any personal information that Medicare collects kept private. Medicare may collect information about you as part of its regular business, such as paying your bills. The law requires Medicare to keep this information private. When Medicare asks for this kind of information, we must tell you that the law lets us collect it for payment and health treatment purposes. You have the right to know why we need it, whether it is required or optional, what happens if you don't give the information, and how it will be used. If you want this information call 1-800-MEDICARE (1-800-633-4227) and ask for more information about how Medicare uses personal information.

If You Are in a Medicare Managed Care Plan ▸

- You have a right to choose a women's health specialist from your plan's list of doctors to meet your women's health care needs.
- If you have a complex or serious medical condition, you have a right to have enough visits to a specialist to deal with your needs.

If You Are in a Medicare Managed Care Plan (continued) ▸

- You have a right to know how your plan pays its doctors. If you want to know how your plan pays its doctors, the plan must tell you in writing. You also have the right to know whether your doctor owns all or part of a health care facility. For example, a lab that he or she refers you to for a blood test.
- If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a grievance. A grievance is a type of complaint. For example, if you believe your plan's hours of operation should be different, you can file a grievance. If you believe you are not getting a high quality of care, you may either file a grievance with your plan or with the Peer Review Organization (PRO) in your State (see pages 31-32).

Your Medicare Appeal Rights

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or a Medicare managed care plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

Appeal Rights Under The Original Medicare Plan ▸

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

Appeal Rights Under Medicare Managed Care Plans ▸

If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours.

Appeal Rights Under Medicare Managed Care Plans (continued) ▸

The Medicare managed care plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

Your Medicare Protections

You are Protected from Unexpected Bills ▸

An Advance Beneficiary Notice is a written notice that tells you why Medicare probably (or certainly) will not pay for a service. A doctor or supplier might give you this notice before you are given the service. If you still want to get the service, you will be asked to sign an agreement that you will pay for the service yourself if Medicare does not pay for it. Advance Beneficiary Notices are used in the Original Medicare Plan, but not in Medicare managed care plans.

You are Protected From Discrimination ▸

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, sex, national origin, disability, or age. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights in your State (see page 22).

You are Protected When You Are in the Hospital ▸

If you are admitted to a Medicare participating hospital, you should be given a copy of *An Important Message From Medicare*. It explains your rights as a hospital patient. If you are not given one, ask for it.

The Message tells you:

- You have the right to get all of the hospital care that you need, and any follow-up care after you leave the hospital.
- What to do if you think the hospital is making you leave too soon.

If you have questions about this, call the Peer Review Organization (PRO). Their number is on the message. You may be able to stay in the hospital at no charge while they review your case. The hospital cannot force you to leave before the PRO makes a decision.

You are Protected in a Skilled Nursing Facility ▸

A skilled nursing facility (SNF) is a qualified facility that has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Some nursing homes provide this type of skilled care. There are quality standards that every SNF must meet to protect you, including:

- The SNF cannot make you pay anything to be admitted unless it is clear to you that Medicare does not cover the cost of services;
- You must be told right away if the SNF decides you do not need the level of skilled care covered by Medicare. If you disagree with this decision, you may ask that the SNF submit something called a "demand bill" to Medicare.

  The SNF must submit the demand bill and cannot make you pay a deposit for services that Medicare may not cover until Medicare gives its decision.

  You must pay for any coinsurance while the demand bill is being processed, and for services not covered by Medicare.

If you have questions about SNF care, contact your Fiscal Intermediary (see pages 27-28).

You are Protected When Your Home Health Care Ends ▸

Home health agencies must give you a notice that explains why and when they think Medicare will stop paying for your home health care. If you think you still need home health care and you think Medicare should keep paying, you can ask Medicare for an official decision.

To get an official decision, you should:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this.
- Pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay.

If Medicare decides to pay, you will get back all of your payments, except for any coinsurance for durable medical

You are Protected When Your Home Health Care Ends (continued) ▸

equipment. If Medicare decides not to pay, you will get a letter that tells you how to appeal. You can always get home health care if you want to pay for it yourself. If you have questions about home health care under the Original Medicare Plan, call your Regional Home Health Intermediary (see pages 29-30). If you have questions about home health care in a Medicare managed care plan, call your plan.

Your Medigap Policy Protections

You may have the right to buy a Medigap policy, even if you are in poor health. See page 14 for more information about these rights.

You Can Help Protect Yourself and Medicare From Fraud and Abuse

Most doctors and other kinds of health care providers who work with Medicare are honest and want to provide health care to you. There are a few who are not honest. We are working very hard with other government agencies to protect the program from the few who try to cheat Medicare.

With help from you, health care providers, and law enforcement, Medicare is solving this problem. Medicare has sent some dishonest providers to jail, and some have left the Medicare program. These actions have saved money for taxpayers.

What You Can do to Help Fight Fraud and Abuse ▸

Every time you get health care in the Original Medicare Plan, you get an Explanation of Medicare Benefits or a Medicare Summary Notice from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid. Check it for mistakes. Make sure that Medicare wasn't charged for any services or supplies that you did not get. If you see a charge on your bill that may be wrong, call the health care provider and ask about it. If you think that a provider may be cheating or abusing Medicare, call the Medicare Carrier or Fiscal Intermediary. Their phone number is printed on the top of the notice.

What You Can do to Help Fight Fraud and Abuse (continued) ▸

You can also call the Inspector General's hotline to report Medicare fraud. The hotline number is 1-800-HHS-TIPS (1-800-447-8477). Medicare will not use your name if you ask that it not be used.

Fighting fraud and abuse can pay. You may get a reward of up to $1,000 if:

- You report Medicare fraud and abuse,

  AND

- Your report leads directly to the recovery of at least $100 of Medicare money,

  AND

- The fraud and abuse you report is not already being investigated.

If you want to know more about this program, call your Medicare Carrier (see pages 23-24) or Fiscal Intermediary (see pages 27-28).

Whether you are in the Original Medicare Plan, or a Medicare managed care plan, you may want to know:

Q1: What if I'm over 65 and didn't sign up for Part B when I first became eligible?

If you did not take Part B when you were first eligible for Medicare, you may still be able to sign up during a General Enrollment Period.

This happens from January 1 through March 31 of each year. You can sign up for Part A or Part B at your local Social Security office. Your Part B coverage will start on July 1 of that year. Remember, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see below).

Q2: How do I sign up for Part B if I or my spouse continued working after age 65?

Many people retire and start their Medicare Part B coverage when they turn 65. However, you or your spouse might continue working. If so, you may wish to keep any employer or union group health plan coverage that you have through that employment. You don't have to sign up and pay for Part B if you have this other coverage. You will have a Special Enrollment Period that gives you another chance to sign up for Part B later, when you need it.

You can sign up:

1. Anytime you are still covered by the employer or union group health plan, or
2. Within 8 months of the date when your employer or union group plan coverage ends, or when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply.

Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums.

For more information about Part B, call your local Social Security office, or call Social Security at 1-800-772-1213 to sign up for Part B. Railroad Retirees should call the Railroad Retirement Board (see page 22).

Q3: How does travel affect my health care?

A: The Original Medicare Plan generally does not cover care outside the United States, but some Medicare managed care plans and Medigap policies do. If you are a Railroad Retiree, contact the Railroad Retirement Board (RRB) or RRB Carrier for information on their rules about care in another country (see page 22).

Medicare managed care plans require you to live and get your care in the service area of the plan. If you travel a lot or live in another State for part of the year, you should call your plan and ask if they cover services when you are out of the service area temporarily.

Q4: Does Medicare pay for outpatient prescription drugs?

A: The Original Medicare Plan does not cover outpatient prescription drugs except in a few cases, like certain cancer drugs. However, many Medicare managed care plans cover outpatient prescription drugs, up to certain limits. Some Medigap policies also cover certain outpatient prescription drugs.

Q5: If I have Medicare and Medicaid, who should pay my health care bills first?

A: Your bill should always be sent to Medicare first. The part of the bill that Medicare does not pay will then be sent to your State Medicaid program for further payment.

Q6: What does Medicare Secondary Payer mean?

A: Medicare Secondary Payer means that other insurance pays your health care bills first and Medicare pays second. Other insurance that may have to pay first includes: employer group health plan insurance, automobile or non-automobile no-fault insurance, any liability insurance, black lung benefits, and workers' compensation. It is important that you tell your doctor or hospital that you have other insurance. If you have questions about who pays first, call your Medicare Carrier (see pages 23-24).

Q7: What is a "Private Contract," and how does it work?

A: A Private Contract is an agreement between you and a doctor who has decided not to give services through the Medicare program.

Under a private contract:

- Medicare will not pay the doctor or you for the services you get.
- You will have to pay whatever the doctor charges you (there are no limits on the charge).
- Medicare managed care plans will not pay for these services.
- No claim should be submitted. Medicare will not pay if a claim is submitted.
- If you have a Medigap policy, it will not pay anything for services under a private contract. Contact your Medigap insurance company before you get the service.
- Many other insurance plans will not pay for the service either.

The private contract only applies to the services you get from the doctor who asked you to sign it. You cannot be asked to sign a private contract when you are facing an emergency or urgent health situation. You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract (see page 25). You can also call 1-800-MEDICARE (1-800-633-4227) and ask for information on private contracts.

You may choose to pay on your own for services that the Original Medicare Plan does not cover. In this case, your doctor does not have to stop providing services through Medicare or ask you to sign a private contract. You are always free to get non-covered services on your own if you choose to pay for these services yourself.

Q8: What is the year 2000, or "Y2K" computer problem?

A: Most computer software programs use dates with only the last two numbers of the year. Because of this, the year 2000 will show up as 00. The computer will see it as 1900. This could cause problems with many computer systems. To prevent these problems, the government, doctors, hospitals and others who use computers are fixing their computers so they will run smoothly into the year 2000.

Q9: Are Medicare's computers ready for the year 2000?

A: Yes. Medicare's computers are ready for the year 2000. We are also working with health care providers, suppliers, and the companies that handle Medicare bills and payments to be sure that their computers will be ready. You will not have to pay any bills that Medicare would ordinarily pay because of a computer problem. If you need general information or have problems getting a bill paid that you think is related to this computer problem, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

If you are in the Original Medicare Plan, you may want to know:

Q10: How are my bills paid in the Original Medicare Plan?

A: When you get services covered by the Original Medicare Plan, your provider sends the bill to a private company (the Fiscal Intermediary for Part A services or the Medicare Carrier for Part B services) that handles bills for Medicare. After they process the bill, you will get an Explanation of Medicare Benefits or a Medicare Summary Notice. Please check the notice to be sure Medicare was not billed for services, medical supplies, or equipment that you did not get. If you have any questions about bills or services listed on the notice, call the health care provider and ask about it. If you disagree with what is covered or paid, you have the right to file an appeal (see page 38). If you think the provider is being dishonest, read the fraud and abuse section on page 41.

Q11: How can I tell if Medicare was billed for the services that I received?

A: Write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service you have received from your doctor, hospital, or any other health supplier.

Q12: What is "assignment" in the Original Medicare Plan?

A: In the Original Medicare Plan, doctors and other providers who accept assignment accept the amount Medicare approves (the approved amount) for a certain service or supply as payment in full. (You are still responsible for any coinsurance amount.) Always ask your doctors and medical suppliers whether they accept assignment because:

- It could save you money!
- Doctors who do not accept assignment can make you pay the full amount they are allowed to charge at the time of service. Medicare will reimburse you later for its share of the bill.
- Doctors and other health care providers who do not accept assignment may charge up to 15% over Medicare's approved payment amount (the limiting charge). The limiting charge does not always apply.

For more details about assignment, call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of *Does Your Doctor or Supplier Accept Assignment?*

If you are thinking about joining a Medicare managed care plan, you may want to know:

Q13: Why do some Medicare managed care plans leave Medicare?

A: Each year, managed care plans have to choose whether to continue doing business with the Medicare program, and whether to raise or lower premiums and benefits. Some managed care plans make business decisions to leave Medicare in certain areas. Your plan must let you know if it intends to leave Medicare at the end of the year. The notice the plan must send you will tell you if other Medicare managed care plans are offered in your area, and what protections you have.

If the plan's quality is poor or they commit fraud, they can be asked to leave Medicare. You will get a notice before this happens. The notice will tell you how to find a new plan, and what protections you have.

Q14: What can I do if my Medicare managed care plan does not stay with Medicare?

A: If there are other Medicare managed care plans in your area, you may join one. Or, you can return to the Original Medicare Plan. You should learn as much as you can about your options before making a decision. No matter what you choose, you are still in the Medicare program and will get all Medicare covered services. You can read about your Medigap protections on page 14.

Q15: What are primary care doctors?

A: A primary care doctor is usually a family doctor or internist who gives regular, basic health care. In managed care plans, you either choose or are assigned a primary care doctor who belongs to the plan. He or she arranges your health care with you and gives you the OK (see question 16 on page 49) to see specialists who belong to the plan when you need one.

If you already have a doctor or specialist you like, ask if he or she is in the plan and would continue to see you if you join the plan.

Q16: What is a referral?

A: In a Medicare managed care plan, a referral is your primary care doctor's OK for you to see a certain specialist or get certain services. Most Medicare managed care plans require referrals.

Important: You may have to pay the entire bill if:

(1) you see a different doctor from the one on the referral, or

(2) you see a specialist or get a service without a referral.

You don't need a referral for an emergency or urgently needed care (see question 17).

Q17: What is a medical emergency? How do I get emergency care?

A: A medical emergency is when you believe that your health is in serious danger - when every second counts. You may have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse. All Medicare managed care plans must allow you to get emergency care whenever you need it from any provider in the United States. You do not need permission from your primary care doctor first. Your plan must pay for the emergency care. If you get a bill, give it to the plan to pay. If your plan does not pay for your emergency service, you have the right to appeal (see page 38).

Q18: What is "urgently needed care"? How do I get urgently needed care?

A: When you need care for a sudden illness or injury, but it is not a medical emergency, it is called urgently needed care. You get urgently needed care from your primary care doctor. However, if you are out of the Medicare health plan's service area for a short time and cannot wait until you return home, your plan must pay for urgently needed care. If it does not, you have the right to appeal.

If you need special health care, you may want to know:

Q19: How can I get information about home health, hospice, or mental health care, or care in a skilled nursing facility?

A: Medicare pays for a variety of services if you need care at home, hospice care (for terminally ill patients), mental health care, or care in a skilled nursing facility. You must meet certain conditions to qualify for these types of services.

Questions about:

Home Health or **Hospice Care** - Call your Regional Home Health Intermediary (see pages 29-30), or order pamphlets on these topics from 1-800-MEDICARE (1-800-633-4227).

Mental Health Care - Call 1-800-MEDICARE (1-800-633-4227) for more information.

Skilled Nursing Facility Care - Call your Fiscal Intermediary (see pages 27-28), or order a copy of *The Guide to Choosing a Nursing Home* from 1-800-MEDICARE (1-800-633-4227).

You can also find these pamphlets on the Internet at www.medicare.gov.

Q20: What is long-term care?

A: Long-term care is care that helps you with your daily needs, such as bathing, dressing, toileting, and eating. This care can be provided safely and easily by people without professional skills or training. You can get long-term care at home or in a nursing home if you are disabled or have a long-term illness. See question 21 for payment information.

Q21: Who pays for long-term care?

Generally, Medicare does not pay for long-term care. If your income and assets are limited, your State may be able to help you pay for long-term care. If you qualify for both Medicare and Medicaid, most health care costs are covered. You may also qualify for the Medicaid nursing home benefit. Call your state medical assistance office for more information (see page 34).

You can buy long-term care insurance from a private insurance company, but be sure that the agent is licensed in your State. Each policy may be different. Contact your State Health Insurance Assistance Program for more information (see page 25) or write to National Association of Insurance Commissioners, Publications Dept., 120 West 12th Street, Suite 1100, Kansas City, MO 64105. Ask for a copy of *The Shopper's Guide to Long-Term Care Insurance*. You may also call 1-800-MEDICARE (1-800-633-4227) to get a copy of the *Guide to Health Insurance for People with Medicare*.

Q22: How can I find out about the nursing homes in my area?

A: You can now get important information about the nursing homes in your area on the Internet at www.medicare.gov. Click on "Nursing Home Compare" to see where they are located in your area, how big they are, and if there have been problems. If you don't have a computer, your local library or senior center may be able to help you look at this information.

Free Medicare and Related Publications

To ask for a copy of...

- *Does Your Doctor or Supplier Accept Assignment?*
- *Guide to Choosing a Nursing Home*
- *Guide to Health Insurance for People With Medicare*
- *Health Plan Comparison Information*
- *Learning About Medicare Health Plans*
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*
- *Medicare Health Plan Quality and Satisfaction Information*
- *Medicare Home Health Care Services*
- *Medicare Hospice Benefits*
- *Medicare Preventive Services*
- *Medicare Supplemental Insurance (Medigap) Policies and Protections*
- *Medicare & You (Available in English, Spanish, Audio-tape, or Braille)*
- *Worksheet for Comparing Medicare Health Plans*
- *Your Guide to Medicare Medical Savings Accounts*
- *Your Guide to Private Fee-for-Service Plans*

Call: 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

To request a copy of...

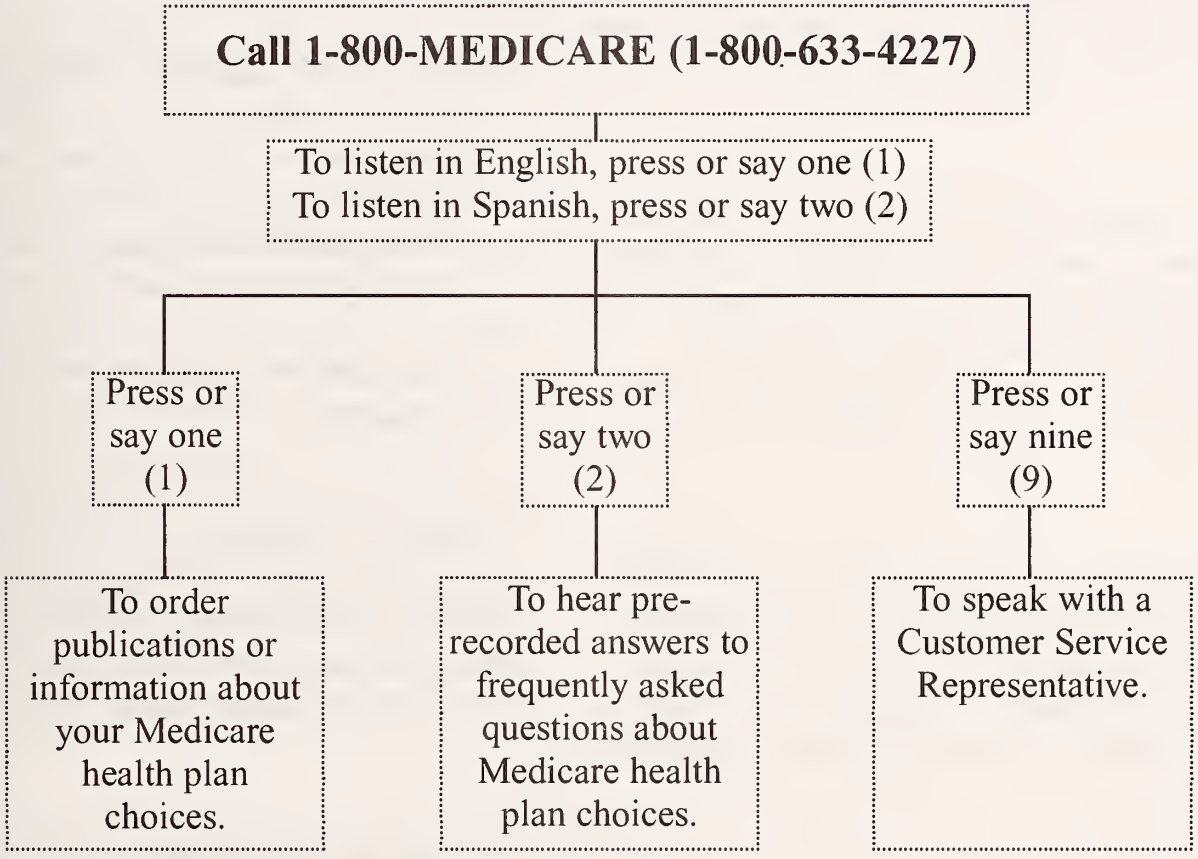
- *A Shopper's Guide to Long-term Care Insurance*

Write to:

NAIC
Publications Dept.,
120 West 12th Street
Suite 1100
Kansas City, MO 64105

Call 1-800-MEDICARE to:

- Get more help with your questions about Medicare.
- Order Medicare publications. (Some are available in Spanish, audio-tape, and braille.)
- Order detailed information about the Medicare managed care plans in your area.
- Order Medicare health plan quality and customer satisfaction information.
- Listen to recorded questions and answers on topics such as Medicare health plan choices, and health plan quality information.



Important Facts About 1-800-MEDICARE

If you are hearing or speech impaired, call our TTY/ TDD line toll-free at 1-877-486-2048 for these options.

If you have a touch-tone phone, press the numbers listed. If you have a rotary phone, or if it is hard to dial, after you have dialed 1-800-633-4227 you can just say the numbers to request what you want.

You can hear a recording with answers to frequently asked questions, and can order publications 24 hours a day, 7 days a week.

You can talk with a Customer Service Representative between 8:00 a.m. and 4:30 p.m. in your time zone, Monday through Friday.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance - The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service you get, like a doctor visit. In the Medicare program, a copayment is usually a fixed amount you pay for a service, like $5 or $10.

Deductible - The amount you must pay for health care, before Medicare begins to pay. There is a deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

Medicaid - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary - Services or supplies that:

- are proper and needed for the diagnosis, or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Medicare + Choice - A new Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Peer Review Organization (PRO) - Groups of practicing doctors and other health care experts paid by the Federal Government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers.

Premium -Your monthly payment for health care coverage to Medicare, an insurance company, or a health care plan.

Reserve Days - Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($384 in 1999).

Skilled Care - A level of care that must be given or managed by licensed health care professionals and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including giving direct services. As long as you need skilled care, it makes no difference whether your illness is acute, chronic, or terminal. Any service that could be safely performed by an average nonmedical person (or one's self), without the direct supervision of a licensed health care professional, is not covered.

State Health Insurance Assistance Program (SHIP) - A State organization that receives money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

Page(s)

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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National Medicare Handbook; with a listing of important phone numbers for your area.

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Call 1-800-MEDICARE (1-800-633-4227) or look on the Internet at www.medicare.gov to get help with your Medicare questions.

¿Necesita usted una copia en Español? Por favor llame al 1-800-633-4227, TTY/TDD: 1-877-486-2048 para personas con impedimento auditivo.

1999 Guide

To Health Insurance for People with Medicare

A Guide For:

- Purchasing Medigap Insurance
- Using Medigap Insurance
- Other Kinds of Health Insurance

Developed jointly by the
National Association of Insurance Commissioners
and the
Health Care Financing Administration of the U. S. Department of Health and Human Services

HEALTH CARE FINANCING ADMINISTRATION

Table of Contents

Index And Telephone Directory ▶

If You Have Questions

The Guide To Health Insurance for People with Medicare supplements the Medicare handbook, now called *Medicare & You*. This guide's primary purpose is to offer you help in purchasing and using Medicare supplemental or Medigap insurance.

We have included information on some of the most frequently asked questions about the Original Medicare Plan and Medicare supplemental policies. Check the index on page 59 for the information you need. The index provides an alphabetical listing of all the major topics discussed in this guide. If your questions are not answered, use the telephone directory starting on page 47. Telephone numbers for each of the State Agencies on Aging, State Health Insurance Assistance Programs, and the state insurance departments are listed in the directory. These organizations can help you with questions you may have about most health insurance issues.

If you are a new Medicare beneficiary, the Medicare handbook is automatically mailed to your house around the same time as your Medicare card. Starting in late 1999, all other beneficiaries will receive a copy of the Medicare handbook each year in the mail.

What's New in 1999?

This guide is completely redesigned; we hope it is easier to use. HCFA welcomes your comments and suggestions about *The Guide To Health Insurance for People with Medicare*. We may be unable to respond to all comments, but your comments may help us make improvements to future versions of this guide.

Send your comments to:
Health Care Financing Administration
Guide To Health Insurance Comments
7500 Security Boulevard
Baltimore, Maryland 21244-1850

HCFA publishes a number of booklets and pamphlets on specific parts of the Medicare program. You can request these publications by calling the Medicare Hotline at 1-800-638-6833. You can also see or print them from the internet at www.medicare.gov.

What Is "Supplemental" Or Supplemental Insurance?

There are many types of private health insurance/coverage that will pay for some or all of your health care costs not covered by Medicare. These types of private health insurance/coverage include:

- Employee Coverage (from your employer or union);
- Retiree Coverage (from your employer or union); and
- Medigap Insurance (from a private company or group).

People often refer to all of these types of private health insurance/coverage as "supplemental." However, "Medicare Supplemental" or "Medigap" insurance is a specific type of private insurance that is subject to federal and state laws.

This guide can give you some useful information on all the types of supplemental insurance/coverage discussed above. However, the main focus of this guide is to provide you with important information about Medigap insurance.

How Do You Know If Your Supplemental Insurance Is A Medigap Policy?

Medigap insurance is specifically designed to fill "gaps" in Original Medicare Plan coverage. It will generally not pay benefits if you are enrolled in a Medicare health plan (e.g. Medicare Managed Care Plan or HMO). Any policy that is a Medigap policy will be clearly identified as "Medicare Supplemental Insurance". Medigap policies provide specific benefits that are grouped in 10 standardized Medigap plans (see page 14).

If you aren't sure if your supplemental insurance/coverage is a Medigap policy, ask your insurance company or check your policy.

Caution

Do You Need A Medigap Policy If You Are On Medicaid?

- If you are on Medicaid, you do not need a Medigap policy. In fact, it is illegal for anyone to sell you a Medigap policy if they know you are on Medicaid.
- If you already have a Medigap policy and go on Medicaid, see page 43.

What Is In This Guide?

Original Medicare Plan:
The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan.

Medigap:
A Medicare supplemental insurance policy that is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. There are 10 standardized policies, labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Medicare SELECT:
A type of Medigap policy that must meet all of the requirements that apply to a Medigap policy, and may require you to use doctors and hospitals within its network in order for you to be eligible for full benefits.

* Throughout the rest of this book, the term "Medicare supplemental insurance policy" will be referred to as "Medigap policy".

Highlighted words are defined in this column throughout this Guide, and can be found in the Glossary Of Terms on page 55.

The Original Medicare Plan pays for much of your health care, but not all of it. To get more coverage, you may have an employer or union sponsored health plan or you may purchase a Medicare supplemental insurance policy from a private insurance company (also known as Medigap or Medicare SELECT)* or you may consider joining a Medicare health plan.

The National Association of Insurance Commissioners (NAIC) and the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services have written this guide to give you information that should help you:

- Learn about Medicare and Medigap.
- Identify what the Original Medicare Plan does not cover in full or at all (the gaps in your coverage).
- Decide whether or not to purchase a Medigap policy if you have the Original Medicare Plan.
- Know what is important to consider when purchasing a Medigap policy.
- Learn about using Medigap policies and other related issues.
- Find the name and telephone numbers of state agencies that can answer your questions about health insurance.

This guide does not recommend insurance companies or policies.

Words that may be new to you are explained the first time they are used. If you want to know more about new words, you can look in the "Glossary" on page 55. In the glossary, many of the words used in this guide are defined more completely.

Introduction

How To Use This Guide

The Guide has 4 sections:

Section 1 - Let's Start With The Basics: The Original Medicare Plan
- What is covered;
- What are the gaps; and
- How to get more coverage and/or reduce out-of-pocket costs.

Section 2 - Purchasing a Medigap Policy
- What Medigap covers;
- The types of Medigap policies available;
- Medigap benefits;
- The best time to buy; and
- Medigap for people under age 65.

Section 3 - Using Medigap Insurance
- Filing claims;
- Protections and guarantees;
- Switching policies; and
- Other protections.

Section 4 - Other Kinds Of Health Insurance
- Group insurance;
- Employee coverage;
- Retiree coverage;
- Medigap and retiree coverage;
- Special rules for those with employed spouses;
- Other options; and
- Long-term care insurance.

Gaps:
The costs or services that are not covered under the Original Medicare Plan.

Out-of-Pocket Costs:
Health care costs that you must pay on your own because they are not paid by Medicare (see page 7).

Protections and Guarantees:
Your rights to buy Medigap coverage in certain cases (see page 30).

Long-term Care:
Custodial care provided at home or in a nursing home for people with chronic disabilities and prolonged illness. Long-term care is not covered by Medicare.

Deductible:
The amount you must pay before Medicare begins to pay:
- each benefit period for Part A;
- each year for Part B.

Coinsurance:
The percent of the Medicare-approved charge that you have to pay:
- after you pay the Part A deductible;
- after you pay the $100 deductible each year for Part B.

Premium:
Periodic payment for health care coverage to:
- Medicare,
- an insurance company, or
- a health care plan.

Fiscal Intermediary:
A private company that has contracted with Medicare to process bills and pay claims for Part A services.

Medicare Is A Health Insurance Program For:

- People 65 years of age and older.
- Certain people with disabilities under age 65.
- People with End-Stage Renal Disease (ESRD), (people with permanent kidney failure who need dialysis or a transplant).

What Is The Original Medicare Plan?

The Original Medicare Plan is the traditional pay-per-visit arrangement. You can go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Then Medicare pays its share, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

What Is Part A (Hospital Insurance)?

Part A (Hospital Insurance) helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care. If you are eligible (see below), Part A is premium free. That is, you don't pay a premium because you or your spouse paid Medicare taxes while you were working. Your Fiscal Intermediary can answer your questions on what Part A services Medicare will pay for and how much will be paid (see page 46).

You are eligible for premium-free Medicare Part A (Hospital Insurance) if:

- You are 65 or older. You are receiving or eligible for retirement benefits from Social Security or the Railroad Retirement Board, or
- You are under 65. You have received Social Security disability benefits for 24 months, or
- You are under 65. You have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or
- You or your spouse had Medicare-covered government employment, or
- You are under 65 and have End-Stage Renal Disease (ESRD).

If you don't qualify for premium-free Part A, and you are 65 or older, you may be able to buy it. Contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Medicare Carrier:
A private company that contracts with Medicare to process beneficiary bills (claims) for Part B services.

What Is Part B (Medical Insurance)?

Part B (Medical Insurance) helps pay for doctors, outpatient hospital care and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists. Part B covers all doctor services that are medically necessary unless you get them from doctors with whom you have a private contract (see page 29). Beneficiaries may get these services anywhere (a doctor's office, clinic, nursing home, hospital, or at home). Your Medicare carrier can answer questions about Part B services and coverage (see pages 51-52).

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are a United States citizen or permanent resident age 65 or older. Part B costs $45.50 per month in 1999.

Part B is voluntary. If you choose to have Part B, the monthly premium is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement payment. Beneficiaries who do not get any of these payments are billed by Medicare every 3 months.

If you didn't take Part B when you were first eligible, you can sign up during 2 enrollment periods:

- **General Enrollment Period**: If you didn't take Part B, you can only sign up during the General Enrollment Period, January 1 through March 31 of each year. Your Part B coverage is effective July 1. Your monthly Part B premium may be higher. The Part B premium increases 10% for each 12-month period that you could have had Part B but did not take it.

- **Special Enrollment Period**: If you didn't take Part B because you or your spouse currently work and have group health plan coverage through your current employer or union, you can sign up for Part B during the Special Enrollment Period. You can sign up at any time you are covered under the group plan. In addition, if the employment or group health coverage ends, you have 8 months to sign up. The 8-month period starts the month your employment ends or the group health coverage ends, whichever comes first. Generally, your monthly Part B premium is not increased when you sign up for Part B during the Special Enrollment Period. Contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778), or the Railroad Retirement Board at 1-800-808-0772 to sign up for Part B.

Deductible:
The amount you must pay before Medicare begins to pay:
- each benefit period for Part A;
- each year for Part B.

Coinsurance:
The percent of the Medicare-approved charge that you have to pay:
- after you pay the Part A deductible;
- after you pay the $100 deductible each year for Part B.

Assignment:
In the Original Medicare Plan, a process through which a doctor or supplier agrees to accept the amount Medicare approves as payment in full. (You must pay any coinsurance amount.)

For more information about:
- purchasing a Medigap policy, see Section 2, page 12
- using Medigap insurance, see Section 3, page 28
- other kinds of health insurance, see Section 4, page 35
- Medicare health plan choices, see Appendix, page 53.

What Are Your "Out-of-Pocket" Costs?

The Original Medicare Plan pays for much of your health care, but not all of it. (See Medicare Part A (Hospital Insurance) covered services and Medicare Part B (Medical Insurance) covered services on page 8-9). Your "out-of-pocket" costs for health care will include your monthly Part B premium ($45.50 per month in 1999). You will have to pay deductibles and coinsurance when you get health care services.

Generally, you will pay for your outpatient prescription drugs. You also pay for routine physicals, nursing home (custodial) care, most dental care, dentures, routine foot care, and hearing aids. There are yearly limits on what Medicare will pay for physical therapy and occupational therapy services unless you get them in a hospital outpatient department, or through home health agencies. The Original Medicare Plan pays for some, but not all, preventive care (see page 10).

Your Out-of-Pocket Costs May Depend On:

- Whether your doctor accepts assignment.
- How often you need health care.
- What type of health care you need.

How Can I Get More Coverage and/or Reduce My Out-of-Pocket Costs?

- Keep your employer or union sponsored health coverage, or
- Buy a Medigap policy, or
- Join a Medicare health plan other than the Original Medicare Plan (see Appendix, page 53).

Caution

Any decision about your health care is an important one. You should make your decision carefully and with the help of people you trust. If you or your spouse currently have employer or retiree health coverage that supplements Medicare, check the information provided by your employer or union, and contact them before you choose a new plan. If you have Medigap coverage, check the information provided by your Medigap insurance company, or call the State Health Insurance Assistance Program in your State before you choose a new policy (see page 48). If you have Medicaid coverage, do not make changes until you contact your State Medical Assistance Office (see page 46).

Medicare Part A (Hospital Insurance) Covered Services

Covered Services	What You Pay in 1999
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies (but not private duty nursing, a television or telephone in your room, or a private room unless medically necessary).	For each benefit period you pay: ■ A total of $768 for a hospital stay of 1-60 days. ■ $192 per day for days 61-90 of a hospital stay. ■ $384 per day for days 91-150 of a hospital stay.* ■ All costs for each day after 150 days.
Skilled Nursing Facility (SNF) Care**: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies.	For each benefit period you pay: ■ Nothing for the first 20 days. ■ Up to $96.00 per day for days 21-100. ■ All costs after day 100 in the benefit period. Call your Fiscal Intermediary with questions about skilled nursing facility care and conditions of coverage (see page 46).
Home Health Care**: Intermittent skilled nursing care, physical therapy, occupational therapy, speech language pathology services, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	You pay: ■ Nothing for Home Health Care services. ■ 20% of approved amount for durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Call your Regional Home Health Intermediary with questions about home health care and conditions of coverage (see page 46).
Hospice Care**: Pain and symptom relief, and supportive services for the care of a terminal illness. Home care is provided. Also covers necessary inpatient care and a variety of services usually not covered by Medicare.	You pay: ■ Limited costs for outpatient drugs and inpatient respite care (care given to a hospice patient so that the usual care giver can rest). Call your Regional Home Health Intermediary with questions about hospice care and conditions of coverage (see page 46).
Blood: From a hospital or skilled nursing facility during a covered stay.	You pay: ■ For the first 3 pints.

Benefit Period: Starts the day you go to a hospital or skilled nursing facility and ends when you haven't received hospital inpatient or skilled nursing facility care for 60 days in a row.

* You have 60 lifetime reserve days that may only be used once. For each reserve day, Medicare pays all covered costs except for a daily coinsurance ($384 in 1999).

** You must meet certain conditions for Medicare to cover these services.

Call your Fiscal Intermediary for general questions about your Medicare Part A coverage (see page 46).

Medicare Part B (Medical Insurance) Covered Services

Covered Services	What You Pay in 1999
Medical Expenses: Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment (DME).	You pay: ■ $100 deductible (pay once per year). ■ 20% of approved amount after the deductible, except in the outpatient setting. ■ 50% for most outpatient mental health. ■ 20% of first $1,500 for all physical therapy services and 20% of first $1,500 for all occupational therapy services, and all charges after that. (Hospital outpatient therapy services do not count towards limit.)
Clinical Laboratory Service: Blood tests, urinalysis, and more.	You pay: ■ Nothing for services.
Home Health Care: (under certain conditions.) Intermittent skilled care, home health aide services, DME and supplies, and other services.	You pay: ■ Nothing for services. ■ 20% of approved amount for DME.
Outpatient Hospital Services: Services to find, or treat an illness or injury.	You pay: ■ No less than 20% of the Medicare payment amount (after the deductible).
Blood: As an outpatient, or as part of a Part B covered service.	You pay: ■ For the first 3 pints plus 20% of approved amount for additional pints (after the deductible).

Note: Actual amounts you must pay for coinsurance are higher if the doctor does not accept assignment (see glossary). Call your Medicare carrier if you have questions about your Medicare Part B coverage (see pages 51-52).

Part B also helps pay for:

- X-rays
- Speech language pathology services
- Artificial limbs and eyes
- Arm, leg, back, and neck braces
- Kidney dialysis and kidney transplants
- Under limited circumstances, heart, lung, and liver transplants in a Medicare-approved facility
- Preventive services (see page 10)
- Very limited outpatient drugs
- Emergency care
- Limited chiropractic services
- Medical supplies: items such as ostomy bags, surgical dressings, splints, and casts
- Breast prostheses following a mastectomy
- Ambulance services (limited coverage)
- The services of practitioners such as clinical psychologists, clinical social workers, and nurse practitioners
- One pair of eyeglasses after cataract surgery with an intraocular lens

Medicare Preventive Services - Added Benefits to Help You Stay Healthy

Covered Service	Eligible Beneficiaries	What You Pay in 1999
Screening Mammogram: Once per year.	All female Medicare beneficiaries age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once per year if you are high risk for cervical or vaginal cancer, or if you are of child bearing age and have had an abnormal Pap smear in the preceding three years.	All female Medicare beneficiaries.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare-approved amount with no Part B deductible.
Colorectal Cancer Screening: Fecal Occult Blood Test: Once every year. Flexible Sigmoidoscopy: Once every four years. Colonoscopy: Once every two years if you are high risk for cancer of the colon. Barium Enema: Doctor can substitute this for sigmoidoscopy or colonoscopy.	All Medicare beneficiaries age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the annual Part B deductible.
Diabetes Monitoring: Helps pay for glucose monitors, test strips, lancets, and self-management training.	All Medicare beneficiaries with diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the annual Part B deductible.
Bone Mass Measurements: Varies with your health status.	Certain Medicare beneficiaries at risk for losing bone mass.	20% of the Medicare-approved amount after the annual Part B deductible.
Vaccinations: Flu Shot: Once per year. Pneumococcal Vaccination: One may be all you ever need-ask your doctor. Hepatitis B Vaccination: If you are at high or intermediate risk for hepatitis.	All Medicare beneficiaries.	No coinsurance and no Part B deductible for flu or pneumococcal vaccinations. For Hepatitis B vaccination, 20% of the Medicare-approved amount after the annual Part B deductible.

What Are the Gaps In the Original Medicare Plan?

Gaps in the Original Medicare Plan fall into 3 categories:

Categories	Examples of Gaps
What you pay (costs for Medicare covered services)	■ Part A deductible for each benefit period* ■ Part B deductible of $100 per year ■ 20% coinsurance for most covered services
What is partially covered (costs for partially covered services and benefits)	■ Home health care that does not meet certain required conditions ■ First three pints of blood ■ All costs for skilled nursing facility care after day 100 in the benefit period*
What is not covered (costs for non-covered services)	■ Outpatient prescription drugs ■ Eyeglasses ■ Hearing Aids ■ Routine Physical Exams ■ Emergency Care Outside the U.S. ■ Custodial Care**

* Benefit Period: A way to measure your use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day you go to a hospital or skilled nursing facility. It ends after you haven't received hospital or skilled nursing care for 60 days in a row (see page 55).

** NOTE: It is important to remember that purely custodial care (the type of care most people in nursing homes need) is not covered by Medicare or most Medigap policies. The only nursing home care that Medicare covers is skilled nursing care that is provided in a Medicare-certified skilled nursing facility typically needed after a serious illness or hospital stay.

Original Medicare Plan:
The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan.

Medigap:
A Medicare supplement insurance policy that is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. There are 10 standardized policies, labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Gaps:
The costs or services that are not covered under the Original Medicare Plan like deductibles, prescription drugs, and coinsurance.

For more information on these Medicare health plans, see Appendix, page 53 ▶

See chart on page 14 for a summary of Medigap policy benefits.

Purchasing Medigap Insurance

If you choose the Original Medicare Plan rather than one of the other Medicare health plans, you may decide that you need more coverage than the Original Medicare Plan provides. Medigap policies only work with the Original Medicare Plan. Many private insurance companies sell Medigap policies for the specific purpose of filling the "gaps" in Original Medicare Plan coverage. These policies must be clearly identified as Medigap policies and must provide specific benefits that help fill in gaps in your Original Medicare Plan coverage. Similar coverage may also be available to retirees through an employer or union health coverage. Other types of insurance may also be available to you to help with out-of-pocket health care costs, but they are not Medigap policies (see page 35).

In all States except Minnesota, Massachusetts, and Wisconsin, federal law limits the Medigap policies that companies may offer to standard supplemental plans. These 10 plans must be labeled with the letters A through J to make it simple to compare plans. State law may limit the types of Medigap policies that are actually sold in your State.

You do not need to buy a Medigap policy if you are enrolled in a:

- Medicare Managed Care Plan
- Private Fee-For-Service Plan
- Medicare Medical Savings Account Plan
- Religious Fraternal Benefit Plan

In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are enrolled in one of these Medicare health plans.

What Medigap Covers

Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance amounts and may provide coverage for the Original Medicare Plan deductibles. Some of the 10 standardized plans pay for services not covered by Medicare such as outpatient prescription drugs, preventive screening, and emergency medical care while traveling outside the United States. Some Medigap policies cover health care provider charges in excess of Medicare's approved amount, and for some care in your home. Benefits for each of the 10 standardized plans are described on pages 16-19.

When describing the benefits of each of the Medigap policies, insurance companies must use the same format, language, and definitions. They also are required to use a uniform chart and outline of coverage to summarize the benefits in each plan (see pages 16-19). These requirements make it easier for you to compare policies. As you shop for a Medigap policy, keep in mind that each company's benefits are alike, so they are competing on service, reliability, and price. Compare benefits and premiums and be satisfied that the insurance company is honest and reliable before buying.

Besides the benefits in standardized plans, federal law permits States to allow an insurer to add "new and innovative benefits" to a standardized plan. Check with your insurance company to find out whether these benefits are available.

What Are Your Medigap Options?

Standardized Medigap Plans ▶

The 10 standardized policies are detailed beginning on page 16. They are called "A" through "J". Plan A is the "basic" benefit package. Each of the other 9 plans includes the basic Plan A package, plus a different combination of additional benefits. Plan J provides the most coverage of all the plans. The plans cover specific costs either not covered or not fully covered by Medicare. Insurance companies cannot change the combination of benefits or the letter names of any of the policies, although a company may add a name for each policy.

Medicare SELECT ▶

Medicare SELECT is a type of standardized Medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans. The only difference between Medicare SELECT and Standardized Medigap insurance is that each insurance company has specific hospitals, and in some cases specific doctors, that you must use, except in an emergency, to be eligible for full supplemental insurance benefits. Medicare SELECT policies generally have lower premiums because of this requirement.

When you go to the Medicare SELECT "preferred providers," Medicare pays its share of the approved charges and the insurance company is responsible for all supplemental benefits in the Medicare SELECT policy. In general, Medicare SELECT policies are not required to pay any benefits if you do not use a preferred provider for non-emergency services. Medicare, however, will still pay its share of approved charges no matter what provider you choose.

Chart of Ten Standardized Medigap Policies

Medigap can only be sold in 10 standardized plans. This chart shows the benefits included in each plan. Every company offers Plan A. Companies may have some, all, or none of the other plans. Some plans may not be available in your State. More detailed information about the benefits in this chart are found on pages 16-19.

Basic Benefits: Included in All Plans.

- Hospitalization: Part A coinsurance plus coverage for 365 additional days during your lifetime after Medicare benefits end.
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
- Blood: First 3 pints of blood each year.

MEDIGAP BENEFITS	A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Inpatient Hospital Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Skilled-Nursing Facility Co-Insurance			✓	✓	✓	✓	✓	✓	✓	✓
Part B: Deductible			✓			✓				✓
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Part B: Excess Charges						100%	80%		100%	100%
Preventive Care					✓					✓
Prescription Drugs (see page 15)								Basic ✓ coverage	Basic ✓ coverage	Extended ✓ coverage

* Plans F and J also have a high deductible option (see page 15).

Chart used with permission from the United Seniors Health Cooperative.

Does Medigap Cover Prescription Drugs?

Yes. Plans H and I offer the basic prescription drug benefit. Plan J offers the extended prescription drug benefit.

Basic Prescription Drug Coverage ▶

After you pay the $250 per year deductible, the plan pays 50% of the costs of your prescription drugs up to a maximum of **$1,250** per year.

Extended Prescription Drug Coverage ▶

After you pay the $250 per year deductible, the plan pays 50% of the costs of your prescription drugs up to a maximum of **$3,000** per year.

What Is A "High Deductible Option" And How Does It Affect Your Costs?

High Deductible Option ▶

Insurance companies may offer a "high deductible option" on Plans F and J. If you choose this option, you must pay $1,500 out-of-pocket per year before the plan pays anything.

Insurance policies with a high deductible option generally cost less than those with lower deductibles. Your out-of-pocket costs for services may be higher if you need to see your doctor or go to the hospital.

Remember, with Plans F and J, there are additional deductibles that must be met including a separate prescription drug deductible of $250 per year for Plan J and a separate foreign travel emergency deductible of $250 per year for Plans F and J.

Is There Any Other Important Information I Need To Know?

Other Important Information On Purchasing A Medigap Policy ▶

There are many individual situations involving health coverage changes (like losing Medicare health plan coverage or employer coverage) that can affect what Medigap policies you can buy and when. See pages 30-33 for information on protections and guarantees for these special situations.

Standardized Medigap Plans

Following is a list of the 10 standardized plans and the benefits provided by each:

Plan A ▶

Plan A has these basic benefits:

Basic Benefits:
Benefits provided in Medigap Plan A. They are also included in all the other Medigap plans.

- Coverage for the Part A coinsurance amount ($192 per day, in 1999) for days 61 through 90 of a hospital stay in each Medicare benefit period.
- Coverage for the Part A coinsurance amount for days 91-150 of a hospital stay ($384 per day, in 1999) for each of Medicare's 60 lifetime reserve days that may only be used once.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during your lifetime. You may be responsible for payment when Medigap hospital benefits are exhausted.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless this blood is replaced.
- Coverage for the coinsurance amount for Part B services (generally 20% of Medicare-approved amount) after $100 annual deductible is met.

Plan B ▶

Plan B has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).

Plan C ▶

Plan C has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- Coverage for the Medicare Part B deductible ($100 per calendar year, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Plan D ▶

Plan D has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (like bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery.

Plan E ▶

Plan E has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for things like a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.

Plan F ▶

High deductible option permitted (see page 15)

Excess Charge (Medigap): The difference between a doctor's or other healthcare provider's actual charge (up to the amount of charge limitation set by Medicare or the state) and the Medicare-approved payment amount.

Plan G ▶

Plan H ▶

Plan F has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- Coverage for the Medicare Part B deductible ($100 per calendar year, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for 100% of Medicare Part B excess charges.

Plan G has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (like bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery.
- Coverage for 80% of Medicare Part B excess charges.

Plan H has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for 50% of the cost of prescription drugs up to a maximum of $1,250 per year after you meet a $250 deductible per year (basic prescription drug benefit).

Plan I ▶

Plan I has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (like bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery.
- Coverage for 100% of Medicare Part B excess charges.
- Coverage for 50% of the cost of prescription drugs up to a maximum of $1,250 per year after you meet a $250 deductible per year (basic prescription drug benefit).

Excess Charge (Medigap):
The difference between a doctor's or other healthcare provider's actual charge (up to the amount of charge limitation set by Medicare or the state) and the Medicare-approved payment amount.

Plan J ▶

Plan J has these benefits:

High deductible option permitted (see page 15)

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- Coverage for the Medicare Part B deductible ($100 per calendar year, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (like bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery..
- Coverage for 100% of Medicare Part B excess charges.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for things like a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.
- Coverage for 50% of the costs of prescription drugs up to a maximum of $3,000 per year after you meet a $250 per year deductible ("extended" prescription drug benefit).

Excess Charge (Medigap):
The difference between a doctor's or other healthcare provider's actual charge (up to the amount of charge limitation set by Medicare or the state) and the Medicare-approved payment amount.

Shopping For A Medigap Policy

When shopping for a Medigap policy, think about:

- Medigap Premiums: There are big differences in the premiums insurance companies charge for exactly the same coverage. When comparing premiums, be sure you are comparing identical Medigap plans. Insurance companies use different methods to calculate premiums:
  - Age Rating: Generally this means that the older you are, the more a Medigap policy costs.
  - No Age Rating (also known as community rating): Generally, this means that a company charges one premium for all policyholders regardless of age.

Suppose you buy a Medigap policy at age 65. The following chart shows an example of what happens to your Medigap policy premiums as you get older using each of these types of ratings:

Rating Method	Premium at Age 65	Premium at Age 75	Premium at Age 85
Age Rating	$70	$90	$130
No Age Rating (Community Rating)	$90	$90	$90

- There are actually two different ways companies can age rate: "Issue age" versus "Attained age" rating. In general, if you are buying a Medigap policy which uses age rating, policies with issue age rating will be slightly better in price than attained age policies.

  Issue Age: The way that companies calculate Medigap premiums based on how old you are when you bought the policy. Premiums may change due to inflation, but will not be changed due to changes in your age.

  Attained Age: Premiums will increase as you grow older.

Remember, all premiums may go up each year because of inflation.

- Medical Underwriting: During open enrollment, and with special Medigap protections (see pages 21, 23 and 30-33), companies cannot use medical underwriting or refuse to write you a policy. During other times, companies can refuse to issue a Medigap policy based on your health conditions and companies may medically underwrite any Medigap policy. Medical underwriting is the process that a company uses to determine whether or not to accept your application for insurance, and how much to charge you for that insurance. It usually involves answering medical questions on an application. Some companies may require a review of your medical records.

- Other Features: For some policies, you must belong to a certain group or organization to purchase a policy sold by the group or organization. In addition, some companies may offer innovative benefits or discounts to couples or nonsmokers.

Medigap for People Age 65 and Older

Open Enrollment:
A period of 6 months that starts when you are both 65 or older and enrolled in Part B. During this time, you have the right to buy the Medigap policy of your choice regardless of any health problems you may have.

Pre-existing Condition:
Health problems that required medical treatment within the 6 months before the date that the policy went into effect.

Exclusion Period:
A period of time of up to 6 months when an insurer can delay coverage of a pre-existing condition.

Creditable Coverage:
Any previous health coverage that can be credited toward pre-existing condition restrictions.

Open Enrollment Guarantees Your Right to Medigap Coverage. For a period of 6 months from the date you are both age 65 or older and enrolled in Medicare Part B, you have a right to buy the Medigap policy of your choice, regardless of any health problems you may have.

During this 6-month open enrollment period, you can buy any Medigap policy sold by a company doing Medigap business in your State. The company cannot deny you or use your medical history, health status, or claims experience to change the issuance or effectiveness, or discriminate in the pricing of a Medigap policy. The company can use pre-existing condition restrictions or exclusion periods for up to 6 months. However, insurance companies can't use exclusion periods for pre-existing conditions if you had at least 6 months of creditable coverage. Any new health problem, however, would be covered immediately.

Creditable coverage is health coverage under:

- a group health plan (such as an employer plan);
- health insurance coverage;
- Part A or Part B of Medicare;
- Medicaid;
- a medical program of the Indian Health Service or tribal organization;
- a State health benefits risk pool;
- TRICARE (the health care program for military dependents and retirees, formerly called Champus);
- the Federal Employees Health Benefit Plan;
- a public health plan; or
- a health plan under the Peace Corps Act.

You can't have any breaks in health coverage that are longer than 63 calendar days for this coverage to be credited toward pre-existing conditions restrictions.

Example (Open Enrollment) ▶

John is 68 and has heart disease. He has just enrolled in Medicare Part B. His effective date is November 4, 1998. John has until May 4, 1999 to buy his Medigap policy without his heart disease affecting the cost or type of policy he can choose. After May 4, 1999, John will not have this guarantee.

Your Medicare card shows the dates that your Part A and/or Part B coverage started. If you are 65 or older, you can figure out whether you are in your Medigap open enrollment period by adding 6 months to the effective date of your Part B coverage. If the date is in the future, you are eligible for open enrollment. If the date is in the past, you are generally not eligible. (If you were entitled to Medicare before age 65, see page 23.)

Example (Creditable Coverage) ▶

John is 68 and has heart disease. He has been enrolled in Medicare Part B since November 4, 1998. On March 4, 1999, John buys the Medigap policy of his choice from Company X. Company X is using a 6-month exclusion period for John's pre-existing heart disease condition. However, Company X is giving John 4 months of credit towards the 6-month exclusion period for the time he was enrolled in Medicare Part B before he bought a Medigap policy. John only has 2 months left on the exclusion period for his pre-existing heart disease condition. During these 2 months, Company X will not pay any costs for John's heart disease condition.

Important

Medigap Open Enrollment Issues ▶

Persons Over Age 65 Who Are Working ▶

If you are working, or are the spouse of a working person over age 65 and are covered under an employer or union group health plan when you become eligible for Part B at age 65, carefully consider your options. **Once you enroll in Part B, the 6-month Medigap open enrollment period starts and cannot be extended or repeated.**

Employer Or Union Health Coverage ▶

If you are working, and are covered under an employer or union group health plan that pays most of your medical bills, you will not need a Medigap plan until you are no longer covered under the employer or union plan. You may, therefore, want to wait to take Part B until you are ready to make the best use of your Medigap open enrollment period. If you enroll in Medicare Part B as a supplement to your employer or union plan while it is the primary payer, you will start your Medigap open enrollment period when it is of little use to you. Once you have started

Primary Payer:
The insurance company which pays first on a claim for medical care.

your Medigap open enrollment period at age 65, it cannot be extended or repeated. If you drop Part B and re-enroll during a special enrollment period after you are no longer covered under your employer or union health plan, you will not get another Medigap open enrollment period.

Medical Underwriting:
The process that a company uses to determine whether or not to accept your application for insurance and how much to charge you for that insurance.

Waiting to take Part B so you can make the best use of the Medigap open enrollment period may not be important if you are in good health. In this case, the company would use medical underwriting. The company would probably accept your application for insurance, and charge you a reasonable amount for the insurance. However, this is not a guarantee.

Medigap for People Under Age 65

Medigap Open Enrollment and Persons with Disabilities or ESRD:

- Under federal law, if you become eligible for Part B benefits before age 65 because of a disability or ESRD (permanent kidney failure), you are guaranteed the Medigap policy of your choice when you reach age 65. During the first 6 months you are age 65 and enrolled in Part B, you can buy the Medigap policy of your choice regardless of whether you had enrolled in Part B before you were age 65.

- During the 6 months after you turn 65, you cannot be refused a Medigap policy because of your disability or for other health reasons. This includes Medigap policies that cover outpatient drugs, if they are available. Since Medicare counts as "creditable coverage," you will not have to wait for coverage of pre-existing conditions unless you have been covered under Medicare for less than 6 months.

Several States go beyond federal law and require at least a limited Medigap open enrollment period for Part B beneficiaries under age 65. Check to see whether your State does. Remember, you will be given an open enrollment opportunity when you turn age 65, even if you had an earlier open enrollment under state law.

If you did not buy your Medigap insurance during the open enrollment period, and are still in good health, you may be able to get the policy you want at a good price.

Also, if your Medicare health plan coverage ends or is lost, you may have the special opportunity to purchase a Medigap policy (see page 31).

If you are denied Medigap coverage, you should contact your state insurance department (see page 47).

Tips On Shopping For A Medigap Policy

Whether you need more health insurance is a decision that only you can make. If you decide to buy more insurance, shop carefully. Look for a Medigap policy that you can afford that offers the benefits you think you need most. Here are some helpful tips for you to keep in mind when shopping for health insurance.

Shop Carefully Before You Buy ▶

Medigap policies differ in coverage and cost. Companies differ in the way they price Medigap policies based on age and health status when purchased outside of the open enrollment period. Companies also differ in customer service. Contact different companies and compare the premiums before you buy.

Don't Buy More Policies Than You Need ▶

Medigap policies are designed so that you generally do not need other similar coverage. Duplicate coverage can be expensive and is generally unnecessary. It is illegal for an insurance company to sell you a second Medigap policy unless you state in writing that you intend to cancel the first Medigap policy after the replacement Medigap policy goes into effect. Anyone who sells you a Medigap policy in violation of the various anti-duplication provisions is subject to criminal and/or civil penalties under federal law. Call the Medicare Hotline at 1-800-638-6833 to report suspected violations.

Consider Your Alternatives ▶

Depending on your health care needs and finances, you may want to consider continuing any employee or retiree health coverage you have at work, joining a Medicare Managed Care Plan, or buying a Medigap policy. Further, you may want to consider buying a long-term care insurance policy in addition to Medigap, group coverage, or a Medicare Managed Care Plan.

Check For Pre-Existing Condition Exclusions ▶

In checking a policy before you buy, you should find out whether it limits or excludes coverage for pre-existing conditions. If you have a health problem and the policy limits or excludes coverage for pre-existing health conditions, the insurer might not cover your costs for any care related to that health problem. Medigap policies, however, are required to cover pre-existing conditions after the policy has been in effect for 6 months. Some insurance companies may have shorter waiting periods before covering a pre-existing condition. Other insurance companies may not have any pre-existing condition limitations. If you buy a policy during your open enrollment period, the insurance company must reduce the pre-existing condition exclusion by the amount of creditable coverage (see page 21).

Pre-existing Condition:
Health problems that required medical treatment within the 6 months before the date that the policy went into effect.

Tips On Shopping For A Medigap Policy continued:

Be Careful Of Replacing Existing Coverage ▶

Make sure you have a good reason for switching from one Medigap policy to another—you should only switch for different benefits, better service, or a more affordable price. On the other hand, don't keep inadequate policies simply because you have had them for a long time. If you decide to replace your Medigap policy, you must be given credit for the time you had the old policy toward pre-existing conditions restrictions under the new policy. You must also sign a statement that you plan to cancel the first policy. Do not cancel the first policy until you are sure that you want to keep the new policy. You have a free look period, which is usually 30 days, to decide whether or not to keep the new Medigap policy.

Policy Delivery Or Refunds Should Be Prompt ▶

The insurance company should deliver a policy within 30 days. If it does not, call the company and ask them to put the reason for the delay in writing. If 60 days go by without an answer, call your state insurance department (see page 47).

Prohibited Marketing Practices ▶

It is unlawful for an insurance company or agent to use high pressure tactics to force or frighten you into buying a Medigap policy, or to make false or misleading comparisons to get you to switch from one company or policy to another. Deceptive "cold lead" advertising is also prohibited. This tactic involves mailings to people who might be interested in buying insurance. If you fill in and return the card enclosed in the mailing, the card may be sold to an insurance agent who will try to sell you a policy.

Medigap Policies Are Neither Sold Nor Serviced By The State Or Federal Government ▶

State insurance departments approve Medigap policies sold by private insurance companies but approval only means the company and Medigap policy meet requirements of state law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that they are from the government and later tries to sell you a Medigap policy, report that person to your state insurance department or federal authorities. This type of misrepresentation is illegal. It is also illegal for a company or agent to claim that a Medigap policy has been approved for sale in any State in which it has not received state approval or to use false means to gain approval.

Tips On Shopping For A Medigap Policy continued:

Know With Whom You Are Dealing ▶

An insurance company must meet certain qualifications to do business in your State. You should check with your state insurance department to make sure that any company you are considering is licensed in your State. This is for your protection. Agents must also be licensed by your State and may be required by the State to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy a policy from that person. A business card is not a license.

Keep Agents' And/Or Companies' Names, Addresses, And Telephone Numbers ▶

Write down the agents' and/or companies' names, addresses, and telephone numbers or ask for a business card that has this information.

Take Your Time ▶

Do not be pressured into buying a Medigap policy. Good sales people will not rush you. If you are not certain whether a Medigap policy is what you need, ask the salesperson to explain it to you with a friend or family member present. Keep in mind, however, that if you are within your 6-month open enrollment period (see page 21) or qualify for special protections (see pages 30-33), you will have a limited time period in which to buy the Medigap policy of your choice without special conditions being imposed. Once this 6-month open enrollment or special protection period ends, the Medigap policies available to you may be limited, especially if you have a pre-existing health condition.

If You Decide To Buy, Complete The Application Carefully ▶

Do not believe an insurance agent who says your medical history on an application is not important. Some companies ask for detailed medical information. If you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you did not report. The company also could deny a claim and/or cancel your Medigap policy for treatment of a condition you did not report .

Look For An Outline Of Coverage ▶

You must be given a clearly worded summary of the policy...READ IT CAREFULLY.

Do Not Pay Cash ▶

Pay by check, money order, or bank draft made payable to the insurance company, not to the agent or anyone else. Get a receipt with the insurance company's name, address, and telephone number for your records.

Tips On Shopping For A Medigap Policy continued:

Beware Of Non-Standard Plans ▶

It is illegal for anyone to sell you a policy and call it a Medigap policy if it does not match Medigap standardization requirements. A "retainer agreement" that a doctor offers you to provide certain non-Medicare-covered services and waive the Medicare coinsurance and deductible amounts, may be illegal. If a doctor refuses to see you as a Medicare patient unless you pay him or her an annual fee and sign one of these retainer agreements, you should call the Medicare Hotline at 1-800-638-6833.

How to File Claims

Information on how to file a claim is usually included with your Medigap policy. If you have questions, call your Medigap insurance company to find out how claims are filed, and how to get reimbursed for your out-of-pocket medical expenses.

Carrier Filing Of Medigap Claims ▶

Under most circumstances, when you get medical services that are covered by both Medicare and your Medigap insurance, you may not have to file a separate claim with your Medigap insurer.

By law, the Medicare carrier that processes Medicare Part B claims for your area must send your claims to the Medigap insurance company. The Medigap insurance company will make payments directly to your doctor or provider when the following three conditions are met:

- Your doctor or supplier has signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries;
- Your policy is a Medigap policy; and
- You tell your doctor's office to put on the Medicare claim form that you wish payment of Medigap benefits to be made to the participating doctor or supplier. Your doctor will put your Medigap policy number and company on the Medicare claim form. You will need to sign the claim form.

Assignment:
In the Original Medicare Plan, a process through which a doctor or supplier agrees to accept the amount Medicare approves as payment in full. (You must pay any coinsurance amount.)

When these conditions are met, the Medicare carrier will process the Medicare claim, send the claim to the Medigap insurance company, and generally send you an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN). Your Medigap insurance company will pay benefits directly to your doctor or other provider and send you a notice that it has done so. If you don't get this notice, you can request it from your Medigap insurance company.

If the Medigap insurance company refuses to pay the doctor directly when the above three conditions are met, you should report this to your state insurance department. For more information on Medigap claim filing by the carrier, contact your Medicare carrier (see pages 51-52).

In most cases, Medigap insurance companies have a special agreement with Medicare under which claims are sent directly to the insurance company, even if the doctor does not accept assignment (also called a participation agreement).

Will Medicare And Medigap Pay If I Have A Private Contract?

Important Information You Should Know Before Signing A Private Contract ▶

Medicare and Medigap will **not** pay if you have a private contract with your doctor or other practitioner to receive services that would otherwise be covered by Medicare.

A private contract is a contract between a Medicare beneficiary and a doctor or other practitioner who has decided not to provide services through the Medicare program. This doctor can not bill Medicare for any service or supplies given to any Medicare beneficiary for at least 2 years.

Under a private contract:

- No Medicare payment will be made for the services you receive.
- You will have to pay whatever the doctor or practitioner charges you (the limiting charge will not apply).
- Medicare Managed Care Plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- If you have a Medigap Policy, it will not pay anything for this service. Contact your insurance company before you receive the service.
- Many other insurance plans will not pay for the service either.

Limiting Charge:
The maximum amount doctors and other health care providers who don't accept assignment can charge you for a covered service. The limit is 15% over Medicare's approved payment amount.

The private contract only applies to the services provided by the doctor who asked you to sign it. You cannot be asked to sign a private contract when you are facing an emergency or urgent health situation. You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract (see page 48).

You may choose to pay on your own for services the Original Medicare Plan doesn't cover. In this case, your doctor does not have to stop providing services through Medicare or ask you to sign a private contract. You are always free to get non-covered services on your own if you choose to pay for the service yourself.

Protections and Guarantees

Medigap Protection If You Enroll In Medicare SELECT Or Join A Medicare Health Plan Other Than The Original Medicare Plan ▶

You may be able to return to a Medigap policy that you dropped to enroll in a Medicare SELECT policy or a Medicare health plan other than the Original Medicare Plan (for example, a Medicare Managed Care Plan). However (1) this must be the first time that you enrolled in a Medicare health plan or Medicare SELECT policy; (2) you must leave the Medicare health plan or Medicare SELECT policy within one year after joining; and (3) after leaving your Medicare health plan or Medicare SELECT policy, you must apply for your former Medigap policy within 63 calendar days after the health plan coverage ends if your previous Medigap insurance company still sells the policy in your State.

If your previous Medigap policy is not available, you are guaranteed the right to purchase Medigap policies "A", "B", "C", or "F" from any insurance company which sells these plans in your State if you apply within 63 calendar days after coverage ends. In these cases, the insurance company may not:

- deny or condition the sale of the policy or discriminate in the pricing of the policy because of your health status, prior history of claims experience, receipt of health care or medical condition, or
- impose an exclusion period for any pre-existing condition.

Example ▶

On December 5, 1998, Sam enrolled in a Medicare Managed Care Plan for the first time. Prior to December 5th, Sam had Medigap policy "Plan C". Six months after enrolling in the Medicare Managed Care Plan, Sam decides that he wants to return to his "Plan C" Medigap policy. Sam leaves the Medicare Managed Care Plan on May 12, 1999. For Sam to return to his "Plan C" Medigap policy, he must make sure that his Medigap insurance company still sells this policy, and apply for it by July 14, 1999 (within 63 calendar days).

Medicare SELECT ▶

The protections and guarantees described above may apply when you lose or drop coverage under a Medicare SELECT policy. All rights to buy a Medigap policy under these protections and guarantees include the right to buy a Medicare SELECT policy since it is a type of Medigap policy. If you currently have a Medicare SELECT policy, you also have additional rights for as long as you have this policy that might provide you with better options for changing your insurance coverage. After you have had the Medicare SELECT policy for at least 6 months, you can switch to a regular Medigap policy sold by the same company, as long as the new policy has equal, or less coverage than the Medicare SELECT policy.

Another Option ▶

Even if you do not meet these conditions, your Medigap insurance company may still allow you to buy a similar policy, especially if you are in good health.

Medigap Protection When Other Types Of Health Coverage End Or Are Lost ▶

If you lose health coverage under certain circumstances, you will have a guaranteed right to purchase Medigap policies "A", "B", "C", or "F" that are sold in your State, as long as you apply within 63 calendar days of losing your other health coverage. The circumstances include the following:

- Your Medicare Managed Care Plan, Medicare MSA Plan, or Private Fee-For-Service Plan terminates its participation in Medicare or stops providing care in your area.
- You move outside the plan's service area.
- You leave the plan because it failed to meet its contract obligations to you.
- You were in an employer group health plan that supplemented or was secondary payer to Medicare and the plan terminates coverage (see page 37).
- Your supplemental insurance company terminates your Medigap policy or Medicare SELECT policy (and you're not at fault).

You will be given credit for any previous health coverage you had to meet the pre-existing condition requirement.

Does This Protection Cover Me If I Am Under Age 65 And Eligible For Medicare Because Of A Disability Or ESRD?

If you live in a State where Medigap policies are sold to people under age 65 who are eligible for Medicare due to disability or ESRD, you may have the same protection as those over age 65 if your health insurance ends or is lost. If Medigap insurance companies in your State sell Medigap policies "A", "B", "C", or "F" to people under age 65, they must also make these policies available to you when your health coverage ends or is lost. Call your State Health Insurance Assistance Program for more information (see page 48).

Are There Any Important Records I Should Keep If My Health Coverage Ends Or Is Lost?

Keep a copy of the termination letter that is mailed to you if your plan stops providing care, a dated copy of your Medigap application, and any Medigap company denial letters you receive.

Caution

While you can apply for a Medigap policy before your health coverage ends or is lost, the protections described here will NOT be guaranteed if you voluntarily disenroll or switch before the health coverage ends or is lost. You should keep a copy of your plan's termination letter in case you have to prove that you lost coverage in a situation described above.

Is There Any Other Time When You May Be Guaranteed Issuance Of A Medigap Policy?

You are guaranteed issuance of ANY Medigap policy if:

- when you first became eligible for Medicare at age 65, you enrolled in a Medicare health plan other than the Original Medicare Plan, and
- you then disenroll from that plan within 12 months of the effective date of your enrollment.

You must apply for the Medigap policy within 63 calendar days of disenrolling from the health plan. If you are denied Medigap coverage, you should contact your state insurance department (see page 47).

Summary Of Protections and Guarantees:

Enrollment Situation	Enrollment Options
You lost your health coverage because: ■ your Medicare Managed Care Plan, Medicare MSA plan, or a Private Fee-for-Service Plan terminated its Medicare participation or stopped providing care in your area; or ■ you moved outside the plan's service area; or ■ you left the plan because it failed to meet its contract obligations to you; or ■ you were in an employer group health plan that terminated coverage and was a secondary payer to Medicare; or ■ your Medigap insurance company coverage terminated due to the insurance company's insolvency (and your State does not require continuation or conversion of coverage under the policy); or ■ you leave the plan because it failed to meet its contract obligations to you.	If you are age 65 or over, you must be allowed to purchase Medigap policies "A", "B", "C", or "F" that are sold in your State, as long as you apply within 63 calendar days of losing your other health coverage. In some States, if you are under age 65 and entitled to Medicare due to disability or ESRD you must be allowed to purchase any Medigap policy that is otherwise available to beneficiaries under age 65. In either case, the insurance company cannot deny you the policy, place conditions on the policy such as a waiting period, apply a pre-existing condition exclusion, or discriminate in the price of the policy based on your health status.

Summary Of Protections and Guarantees continued:

Enrollment Situation	Enrollment Options
You dropped your Medigap policy to enroll in a Medicare health plan like a Medicare Managed Care Plan or Medicare SELECT policy and (1) this was the first time that you enrolled in a Medicare health plan or Medicare SELECT policy; (2) you left the Medicare health plan or Medicare SELECT policy within one year after joining; and (3) after leaving your Medicare health plan or Medicare SELECT policy, you applied for your former Medigap policy within 63 calendar days after your coverage terminated.	You must be allowed to return to your original Medigap policy, if it is still available from the same insurance company, and, if it is no longer available, you must be allowed to purchase Medigap policies "A", "B", "C", or "F", within 63 calendar days under the same conditions described above.
You enrolled in a Medicare health plan other than the Original Medicare Plan when you first became eligible for Medicare at age 65 and you disenrolled from the Medicare health plan within one year after joining; and you applied for a Medigap policy within 63 calendar days after your coverage ended under the Medicare health plan.	You must be allowed to purchase any Medigap policy sold in your State, with no conditions such as a waiting period and no pre-exisiting condition exclusion, and without discrimination in the price of the policy based on your health status, within 63 calendar days after your health plan coverage ends.

All rights to buy Medigap policies under these protections and guarantees include Medicare SELECT policies since they are a type of Medigap policy.

Switching Medigap Policies

Many Federal requirements do not apply to Medigap policies sold before 1992, when Medigap was standardized. There is generally no requirement that you switch to one of the standardized plans if you have an older Medigap policy. However, you may be required to switch if your older policy was not guaranteed renewable and the company discontinues the type of Medigap policy you have. Even if you are not required to convert an older Medigap policy, you may want to consider switching to one of the standardized Medigap policies if you have an older Medigap policy and you want to change for better rates and/or service.

If you do switch policies, you will not be allowed to go back to the old or pre-standardized Medigap policy. If you decide to switch to a standardized Medigap policy, you may face medical underwriting. Before switching, compare benefits and premiums. Some of the older Medigap policies may provide better coverage, especially for prescription drugs and extended skilled nursing care. On the other hand, older Medigap policies, which cannot be sold to new applicants, may have bigger premium increases than newer standardized Medigap policies, which can enroll new applicants.

Medical Underwriting:
The process that a company uses to determine whether or not to accept your application for insurance, and how much to charge you for that insurance.

If you have had a Medigap policy for at least 6 months and you decide to switch, the new Medigap policy generally cannot impose an exclusion period for a pre-existing condition. If, however, a benefit is included in the new Medigap policy that was not in the old Medigap policy, a waiting period of up to 6 months may be applied to that particular benefit.

You do not need more than one Medigap policy. If you already have a Medigap policy, you must sign a statement before you buy another one saying that you plan to replace your current Medigap policy and will not keep both Medigap policies. However, do not cancel the old Medigap policy until the new one is in force and the pre-existing condition period is over, and you have decided to keep the new Medigap policy.

Pre-existing Condition:
Health problems that require medical treatment within the 6 months before the date that the policy went into effect.

Guaranteed Renewable ▶

All standardized Medigap policies are guaranteed renewable. Your insurance company must allow you to renew your Medigap policy unless you do not pay the premiums. Companies may refuse to renew older Medigap policies (sold before 1992) on an individual basis. These older Medigap policies provide the least permanent coverage.

Example ▶

In 1990, Mary bought a Medigap policy from Company A. The Medigap policy Mary bought was not guaranteed renewable. Company A is discontinuing the type of Medigap policy that Mary has. Therefore, Mary must switch to another Medigap policy. Her choices include any one of the ten standardized Medigap policies A through J that are sold in her State.

Group Health Coverage

Group Health Coverage Provided By Employers Or Unions ▶

There are several kinds of coverage that might be called "group" health coverage. Some are offered under group health plans provided by employers or unions for current employees or retirees. Employer plans will generally have better rates than you can get with a policy you buy yourself. Other "group" coverage may be offered to members of an organization or association. Just because you are buying through an association does not mean that you are getting a low rate. Association coverage can be as expensive as, or more costly than, the same coverage under a policy you buy yourself. Be sure you understand the benefits included and then compare prices.

Association Health Coverage ▶

When you reach age 65 you will need to make a decision about Part B (see page 22). You may still have health coverage through your or your spouse's current employer or union membership. If you have this kind of coverage, find out if it can be continued after you retire. Check the price and the benefits, including benefits for your spouse.

Pre-existing Condition: Health problems that required medical treatment within the 6 months before the date that the policy went into effect.

Group health coverage continued after retirement usually has the advantage of having no waiting periods or exclusions for pre-existing conditions. Coverage is usually based on group premium rates, which may be lower than the premium rates for a policy you buy yourself. One note of caution, however. If you have a spouse under age 65 who was covered under your group health plan, make sure you know what effect your continued coverage will have on his or her insurance protection.

More On Retiree Coverage

Retiree coverage that is not a Medigap policy does not have to follow the rules for Medigap policies, but, under some circumstances, must follow the rules of the Department of Labor. These plans have their own rules and might not fill the gaps in Medicare. They might not pay your medical expenses during any period in which you were eligible for Medicare but did not sign up for it. While retiree coverage may not offer the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care. Keep in mind that the retirement coverage provided by your employer or union may have caps or limits on benefits. If you are not sure how your plan works with Medicare, get a copy of the benefits booklet (or look at the Summary Plan Description provided by your employer or union) or call your health plan administrator and ask how the plan pays when you have Medicare.

What Happens If You Drop Employer-Based Coverage?

Caution

If you drop your employer-based group health coverage, you probably won't be able to get it back. Call your health plan administrator for more information.

Other Retiree Health Insurance Options

Retiree Coverage And Medigap ▶

You may buy a Medigap policy even if it duplicates your retiree coverage benefits under a group health plan. The Medigap policy must pay full benefits even if the retiree coverage also pays for the same service. Your retiree coverage may, however, contain a coordination of benefits clause. If it does, it will not pay duplicate benefits. You may want to talk with your State Health Insurance Assistance Program (see page 48) before purchasing a Medigap policy that would duplicate any of your retiree health benefits.

Coordination Of Benefits Clause:
A written statement that tells which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare plan, federal law may decide who pays first.

More Information on Employee And Retiree Coverage

What Health Benefits Must Be Provided If I Am Age 65 Or Older And Still Working?

Employers with 20 or more employees must offer the same benefits, including health benefits under the same conditions, to current employees age 65 and over as they offer to younger employees. If they offer coverage to spouses, they must offer the same coverage to spouses age 65 and over that they offer to spouses under age 65. If your employer and/or employer group health coverage does not follow this rule, you should call the Department of Labor (see page 46).

Sometimes, employee health coverage ends automatically at the end of the calendar year. This could trigger or begin the 63 calendar day period for special Medigap protections and guarantees (see page 30) even before you receive notice from your employer that your coverage has ended. Check with your employer to make sure you understand how your coverage works.

What Happens If You Or Your Spouse Stop Working, And You Are Already Enrolled In Medicare Part B?

You should:

- Notify your Medicare carrier by phone or in writing that you or your spouse's employment situation has changed.
- Give the carrier the name and address of the employer plan, your policy number with the plan, the date coverage stopped, and why.
- When you get health care services, tell the doctor or hospital that Medicare now pays first and should be billed first. Give the date your group health plan coverage stopped.

What Happens If You Or Your Spouse Stop Working, And You Are Not Sure Where To Find The Information You Need To Provide To Your Medicare Carrier?

- Your employer is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to send you a Certificate of Creditable Coverage when your group health coverage ends. All of the information you need to give to the Medicare carrier will be on this certificate. If for some reason your employer does not send you a Certificate of Creditable Coverage, you may ask for one. Certificates are usually provided for free.

Who Pays First

Special Rules For Employees Age 65 Or Over ▶

Secondary Payer:
The insurance company that pays second on a claim for medical care.

If you are age 65 or over, and covered by a group health plan because of current employment or the current employment of a spouse of any age, Medicare is the secondary payer if the employer has 20 or more employees. This means that the plan coverage pays first on your hospital and medical bills. If the plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services after the benefits paid by the group health plan.

If the plan denies the claim entirely, Medicare may pay benefits for Medicare-covered services. This requirement applies to those who have group health coverage as an employee, the spouse of an employee, employer, self-employed person, or a business associate of the employer.

Primary Payer:
The insurance company that pays first on a claim for medical care.

You may accept or reject group health plan coverage from your or your spouse's current employer. If you accept the coverage, the plan will be your primary payer. If you reject the plan, Medicare will be the primary payer for Medicare-covered health care services that you receive. If you reject the plan coverage, the employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or pay for such

coverage in any other way. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical check-ups. If you elect to have Medicare as your primary payer, and you enroll in Medicare Part B, your 6-month Medigap open enrollment period will be triggered (see page 22). To help you decide whether to keep group health plan coverage, talk with your health plan administrator, your state insurance department, or your State Health Insurance Assistance Program (see page 47 or 48).

Special Rules For Disabled Medicare Beneficiaries ▶

Medicare is also the secondary payer for people under age 65 who are entitled to Medicare because of disability and are covered by a large group health plan (LGHP) because of their current employment or the current employment of a family member. A LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees. The secondary payer requirement applies to employers, employees, and members of their families covered by large group health coverage or employer and union sponsored health plans. It also applies to those who have LGHP coverage as a self-employed person, business associate of an employer, or as a family member of one of these people. A LGHP must not treat any of these beneficiaries differently because they are disabled and have Medicare.

Special Rules For Medicare Beneficiaries With End Stage Renal Disease (ESRD) ▶

Medicare is the secondary payer to a group health plan for 30 months for beneficiaries who have Medicare because of ESRD (permanent kidney failure). This applies only to those with ESRD, whether you have plan coverage of your own or as a dependent. The group health plan coverage is the primary payer during this period without regard to the size of the employer-based coverage, the number of employees, or whether the individual or a family member is currently employed.

For more information on ESRD, you may get a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* from the Health Care Financing Administration by calling the Medicare Hotline at 1-800-638-6833.

COBRA Coverage If You Have Health Plan Coverage Through Your Job Or Your Spouse's Job ▶

Employers with 20 or more employees are usually required to offer a temporary extension of their group health coverage to people who lose their group health plan under a law originally enacted by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This may apply to you if you lose your job or have your working hours reduced, or, if you are covered under your spouse's plan and your spouse dies or you get divorced. State law may also impose similar requirements on employers with fewer than 20 employees, but you should check with your state insurance department to make sure (see page 47).

COBRA:
This law requires an employer to allow you to remain covered under the employer's group health plan for a certain length of time after losing your job or having your work hours reduced, or after your spouse's death or a divorce. However, you may have to pay both your share and the employer's share of the premium.

COBRA generally lets you stay in your group health plan for 18 months, but you may have to pay both your share and the employer's share of the premium. If the employer has to follow the federal COBRA requirements, coverage under COBRA may end when you enroll in Medicare. If the continuation coverage is required by State law, your rights will depend on what is allowed under the State law. In most situations that trigger your COBRA rights, other than a divorce, you should receive a notice from your health plan administrator. If you don't receive a notice, or if you get divorced, you should contact your health plan administrator as soon as possible.

Know Who Pays If You Have Other Health Insurance

If you...	Condition	Pays first	Pays second
Are age 65+ and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	■ If the employer has less than 20 employees	■ Medicare	■ Group health plan
	■ The employer has 20 or more employees	■ Group health plan	■ Medicare
Are disabled and covered by a large group health plan of a family member who is working	■ The employer has less than 100 employees	■ Medicare	■ Large group health plan
	■ At least one employer covered by the plan has 100 or more employees	■ Large group health plan	■ Medicare
Have End-Stage Renal Disease (permanent kidney failure), and group health plan coverage	■ First 30 months of eligibility or entitlement to Medicare	■ Group health plan	■ Medicare
	■ After 30 months	■ Medicare	■ Group health plan
Have employer retiree plan	■ Not eligible for Medicare	■ Retiree coverage	■ No insurance
	■ Eligible for Medicare	■ Medicare	■ Retiree coverage

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If you have Medicare and group health plan coverage from a job or union, you should learn who pays first before you go to the doctor or to a hospital.

Other Federal Health Insurance Options

What Is The PACE Program?

The Programs of All-inclusive Care for the Elderly (PACE) is a program that combines both inpatient and outpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent, and living in your community as long as possible, and to provide quality care at low cost.

Services include primary care, social work, restorative therapy, specialty and ancillary medical services, and long-term care services, such as transportation, meals, and personal care. They are provided in the PACE Center, at home, and in other inpatient settings such as a hospital.

An interdisciplinary health care team assesses your needs, develops care plans, and provides services for total care needed. If nursing home placement is needed, PACE provides that service and keeps the continuity of care by regular evaluation and monitoring of your health condition.

PACE sites receive Medicare and Medicaid payments for all eligible enrollees. However, PACE sites are only available in certain communities. To find a PACE site near you, or for more information, please contact your state, county, or local medical assistance office - not a federal office (see page 46). You can also look on the Internet at www.medicare.gov for PACE locations and telephone numbers.

What Is A Federally Qualified Health Center?

Another possible way to lower your health care costs is to go to a Federally Qualified Health Center (FQHC) for the type of care you usually get in a doctor's office. When you use a FQHC, Medicare pays for some health services that are not usually covered like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless. Any Medicare beneficiary may go to a FQHC for health care services. They are usually found in inner-city and rural areas. FQHC services available to Medicare beneficiaries include:

- Routine physical examinations.
- Screening and diagnostic tests for vision and hearing problems, and other health problems.
- Flu Shots and other similar vaccines.

When you get these services at a FQHC, there is no $100 annual Part B deductible. If other services are provided, such as X-rays, you would be responsible for the usual Part B annual deductible of $100. The usual 20

percent coinsurance for Part B services may be waived in some instances. To find the FQHC closest to you, call the Medicare Hotline at 1-800-638-6833.

How Can Medicaid Help Low-Income Medicare Beneficiaries?

Coverage and eligibility requirements vary from State to State, but most of your health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid recipients may also receive benefits such as nursing home care and outpatient prescription drugs.

Medicaid also has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who are entitled to Medicare and have a low income. You must have Medicare hospital insurance (Part A). If you are not sure if you have Part A, look on your Medicare card (red, white and blue card). It will show "Hospital Insurance (Part A)" on the lower left corner of the card. You can also call your local Social Security Administration office, or call SSA at 1-800-772-1213.

If you have Part A, your income is limited (see below), and your financial resources such as bank accounts, stocks, and bonds are not more than $4,000 for an individual, or $6,000 for a couple, you may qualify for assistance as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI).

	1999 Monthly Income Limit*		Program Pays
	Individual	Couple	
QMB	$707	$942	Medicare premiums, deductibles, and coinsurance
SLMB	$844	$1,126	Medicare Part B premium
QI-1	$947	$1,265	Medicare Part B premium
QI-2	$1,222	$1,633	A small part of the Medicare Part B premium

If you think you may qualify, contact your state, county, or local medical assistance office - not a federal office (see page 46).

* Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will change slightly in 2000, and new limits will be available by April 1, 2000.

What If I Have A Medigap Policy And Go On Medicaid?

If you are on Medicaid and have a Medigap policy, you may want to consider suspending the Medigap policy rather than dropping it while you are on Medicaid. By suspending the Medigap policy rather than dropping it, you can start it up again without new medical underwriting or pre-existing condition waiting periods. Call your Medigap insurance company to find out how to suspend a policy. You can only suspend a Medigap policy for up to 2 years.

Can Medicaid Help Pay Health Care Costs For Young Children In My Care Who Are Uninsured?

If you have young children in your care who are uninsured, you may be able to get help to pay for their health care costs under your State's Children's Health Insurance Program. You should contact your state, county, or local medical assistance office to get more information on this program (see page 46).

Other Private Health Insurance Options

The following types of policies are generally limited in scope and are not substitutes for Medigap insurance or comprehensive health coverage. Benefits under these policies are not designed to fill gaps in your Medicare coverage.

Hospital Indemnity Insurance ▶

- Hospital indemnity insurance pays a fixed cash amount for each day you are hospitalized up to a certain number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

Specified Disease Insurance ▶

- Specified disease insurance, which is not available in some States, provides benefits for only a single disease, such as cancer, or for a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Remember, Medicare and any Medigap policy you have will very likely cover costs associated with any specified diseases you may have.

Long-Term Care Insurance

Long-term care involves a wide variety of services for people with a prolonged or chronic physical illness, disability, or cognitive disorder (such as Alzheimer's disease). Long-term care is not one service, but many different services aimed at helping people with chronic conditions deal with limitations in their ability to function independently. Long-term care differs from medical care in that long-term care helps to assist you in remaining as functionally independent as possible. Long-term care services may include, but are not limited to, help with daily activities at

Long-Term Care Insurance continued:

home, such as bathing or dressing, respite care, home health care, adult day care, and care in a nursing home. Medical care is used to find, treat, and correct medical problems. Medical care services may include blood tests to find a health problem, surgery to remove cancer, a cast to fix a broken bone, or medicine to treat an infection.

What Is Long-Term Care Insurance?

Long-term care insurance may cover some of the many different services that may include help with daily activities at home, or fill some gaps in the coverage that you and/or your spouse may need in the future.

If you are shopping for long-term care insurance, find out which types of nursing homes and long-term care services are covered by the different policies available. For more information about long-term care insurance, ask for a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your state insurance department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925. You may also get a copy of the *Guide to Choosing a Nursing Home* from the Health Care Financing Administration by calling the Medicare Hotline at 1-800-638-6833.

Does Medicare Cover Long-Term Care?

Medicare and most Medigap policies do not cover purely custodial care (the type of care most people in nursing homes need). Generally, Medicare only covers skilled nursing care or skilled rehabilitation care that is provided in a Medicare-certified skilled nursing facility (see page 8 for an explanation of the Medicare benefit for skilled nursing facility care).

Who Sells Long-Term Care Insurance?

Private insurance companies sell long-term care insurance policies. They may sell them to individuals through agents or sometimes through the mail without using agents. Some companies sell coverage through senior citizen organizations, fraternal societies, and other groups or associations. Many employers now make long-term care insurance policies available to their employees, their employees' parents, and their retirees. Insurance companies must be licensed in your State to sell long-term care insurance. Be certain that you are dealing with a company that you know. If you decide to buy long-term care insurance, be sure that the company and the agent, if one is involved, is licensed in your State. If you are not sure, contact your state insurance department (see page 47).

For Your Protection

There are federal penalties for certain violations concerning Medicare supplemental insurance (Medigap) policies. It is, for example, illegal for an insurance agent to say that he or she represents the Medicare program or any other federal agency to sell a policy. It is also illegal for an insurance company or agent to sell you a second Medigap policy unless you tell them in writing that you plan to cancel your existing Medigap policy.

It is illegal for anyone to:

- Sell you a second Medigap policy when they know that you already have one.
- Sell you a Medigap policy if they know you are on Medicaid.
- Sell you a Medigap policy if they know you are enrolled in another Medicare plan other than the Original Medicare Plan.
- Claim that a Medigap policy is federally certified.
- Use the mail to advertise Medigap policies that are not approved for sale in your State.
- Misuse the name, letters, symbols, or emblems of the U.S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Health Care Financing Administration (HCFA), or any of their various programs.

You should report any suspected violations of the laws governing the marketing of insurance policies to your state insurance department since States are responsible for the regulation of insurance within their boundaries (see page 47).

If you believe that federal law has been violated, you may call the Medicare Hotline at 1-800-638-6833. In most cases, however, your state insurance department can help you with insurance-related problems (see page 47).

Discrimination

Every facility or agency that participates in Medicare must comply with the law. Laws ban discrimination on the basis of race, color, sex, national origin, disability, or age. If you believe that you have been discriminated against based on any of these categories, contact the Department of Health and Human Services Office of Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697.

Who To Contact

Telephone Directory ▶

The following pages have telephone numbers that you can use if you need more information. For numbers not listed in the telephone directory, call the Medicare Hotline at 1-800-638-6833 or look on the internet at www.medicare.gov.

ate Insurance Department: Call for questions about the Medicare Supplemental Insurance Policies available in your area. ☎

ALABAMA 1-334-269-3550	DISTRICT OF COLUMBIA 1-202-727-8000	KENTUCKY 1-502-564-3630 or 1-800-595-6053	NEBRASKA 1-402-471-2201	OKLAHOMA 1-800-522-0071 (OK only) or 1-405-521-2828	VERMONT 1-802-828-2900 or 1-800-631-7788 (VT only)
ALASKA 1-907-269-7900	FLORIDA 1-800-342-2762 (FL only) or 1-850-922-3100	LOUISIANA 1-800-259-5301 (LA only) or 1-504-342-5301	NEVADA 1-800-992-0900 (NV only) or 1-702-687-4270	OREGON 1-800-722-4134 (OR only) or 1-503-947-7984	VIRGINIA 1-804-371-9691 1-800-552-7945 (VA only)
AMERICAN SAMOA 011-684-633-4116	GEORGIA 1-404-656-2070 or 1-800-656-2298 (GA only)	MAINE 1-207-624-8475 or 1-800-300-5000	NEW HAMPSHIRE 1-603-271-2261 or 1-800-852-3416	PENNSYLVANIA 1-717-787-2317	VIRGIN ISLANDS 1-809-773-6449 ext. 248
ARIZONA 1-602-912-8444	GUAM 1-0-671-475-1817	MARYLAND 1-410-468-2000	NEW JERSEY 1-609-292-5363 1-800-792-8820 (NJ only)	PUERTO RICO 1-787-722-8686	WASHINGTON 1-360-753-3613 or 1-800-562-6900 (WA only)
ARKANSAS 1-800-852-5494	HAWAII 1-808-586-2790	MASSACHUSETTS 1-617-521-7794	NEW MEXICO 1-505-827-4601 or 1-800-947-4722 (NM only)	RHODE ISLAND 1-800-222-2223 or 1-401-222-2880	WEST VIRGINIA 1-304-558-3386 or 1-800-642-9004 (WV only) or TDD 1-800-435-7381
CALIFORNIA 1-800-927-4357 (CA only, except Los Angeles) or 1-213-897-8921 (Los Angeles and out-of-state calls)	IDAHO 1-800-247-4422 (ID only) or 1-208-334-4250	MICHIGAN 1-517-373-0240	NEW YORK 1-800-342-3736 (NY only)	SOUTH CAROLINA 1-800-768-3467 (SC only) or 1-803-737-6180	WISCONSIN 1-608-266-0103 or 1-800-236-8517 (WI only)
	ILLINOIS 1-217-782-4515	MINNESOTA 1-612-296-4026	NORTH CAROLINA 1-800-443-9354 (NC only) or 1-919-733-0111	SOUTH DAKOTA 1-605-773-3656	WYOMING 1-307-777-7401 or 1-800-438-5768 (WY only)
COLORADO 1-800-930-3745 (CO only)	INDIANA 1-800-622-4461 or 1-317-232-2385	MISSISSIPPI 1-601-359-3569 or 1-800-562-2957	NORTH DAKOTA 1-701-328-2440 or 1-800-247-0560 (ND only)	TENNESSEE 1-800-525-2816 or 1-615-741-4955	
CONNECTICUT 1-860-297-3800	IOWA 1-515-281-5705 or 1-515-281-6867	MISSOURI 1-800-726-7390 or 1-573-751-2640	NORTHERN MARIANA ISLANDS Not Available	TEXAS 1-800-252-3439 or 1-512-463-6515	
DELAWARE 1-302-739-6266	KANSAS 1-800-432-2484 (KS only) or 1-785-296-3071	MONTANA 1-406-444-2040 or 1-800-332-6148 (MT only)	OHIO 1-800-686-1526 (OH only) or 1-614-644-2673	UTAH 1-801-538-3805	

State Health Insurance Assistance Program: Call for assistance with Medicare bills, questions about buying a Supplemental Insurance Policy or long term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about you care or treatment, or for help choosing a Medicare health plan.

ALABAMA 1-800-243-5463 (AL only) or 1-334-242-5743	FLORIDA 1-800-963-5337 or 1-850-414-2060	KENTUCKY 1-502-564-7372	MONTANA 1-406-444-7781 or 1-800-332-2272 (MT only)	OHIO 1-614-644-3458	TEXAS 1-800-252-9240
ALASKA 1-800-478-6065 (AK only) or 1-907-269-3680	GEORGIA 1-800-669-8387	LOUISIANA 1-800-259-5301 or 1-504-342-0825	NEBRASKA 1-402-471-2201	OKLAHOMA 1-800-763-2828 (OK only) or 1-405-521-6628	UTAH 1-800-439-3805 (UT only) or 1-801-538-3910
AMERICAN SAMOA 1-808-586-7299	GUAM 1-808-586-7299	MAINE 1-800-750-5353	NEVADA 1-800-307-4444 or 1-702-486-3478	OREGON 1-800-722-4134 (OR only) or 1-503-947-7984	VERMONT 1-800-642-5119 (VT only) or 1-802-748-5182
ARIZONA 1-800-432-4040 or 1-602-542-6595	HAWAII 1-808-586-7299	MARYLAND 1-800-243-3425 (MD only) or 1-410-767-1100 TTY: 1-410-767-1083	NEW HAMPSHIRE 1-603-225-9000	PENNSYLVANIA 1-800-783-7067	VIRGINIA 1-800-552-3402 (VA only) or 1-804-662-9333
ARKANSAS 1-800-852-5494 or 1-501-371-2782	IDAHO 1-800-247-4422 (Boise) 1-800-488-5725 (Lewiston) 1-800-488-5731 (Twin Falls) 1-800-488-5764 (Pocatello)		NEW JERSEY 1-800-792-8820 or 1-877-222-3737 (NJ only)	PUERTO RICO 1-877-725-4300 or 1-787-721-8590	VIRGIN ISLANDS 1-809-778-6311 ext.2338
CALIFORNIA 1-800-510-2020 (CA only) or 1-916-323-7315 (out of state)		MASSACHUSETTS 1-800-882-2003	NEW MEXICO 1-800-432-2080 (NM only) or 1-505-827-7640	RHODE ISLAND 1-401-222-2880 or 1-800-322-2880 (RI only)	WASHINGTON 1-800-397-4422 (WA only) or 1-360-407-0383
COLORADO 1-800-544-9181 (CO only) or 1-303-894-7499 ext. 356	ILLINOIS 1-800-548-9034 (IL only) or 1-217-785-9021	MICHIGAN 1-800-803-7174	NEW YORK 1-800-333-4114 or 1-212-869-3850 (New York City)	SOUTH CAROLINA 1-800-868-9095 (SC only) or 1-803-253-6177	WEST VIRGINIA 1-877-987-4463 or 1-304-558-3317
CONNECTICUT 1-800-994-9422 (CT only) or 1-860-424-5245 (out-of-state)	INDIANA 1-800-452-4800 (IN only) or 1-317-233-3475	MINNESOTA 1-800-333-2433	NORTH CAROLINA 1-800-443-9354 (NC only) or 1-919-733-0111	SOUTH DAKOTA 1-800-822-8804 (SD only) 1-605-773-3656 (Pierre) 1-605-336-2475 (Sioux Falls) 1-605-342-3494 (Rapid City)	WISCONSIN 1-800-242-1060 (WI only) or 1-877-333-0202
DELAWARE 1-800-336-9500 (DE only) or 1-302-739-6266	IOWA 1-800-351-4664	MISSISSIPPI 1-800-948-3090 or 1-601-359-4929	NORTH DAKOTA 1-800-247-0560 or 1-701-328-2977		WYOMING 1-800-856-4398 or 1-307-856-6880
DISTRICT OF COLUMBIA 1-202-676-3900	KANSAS 1-800-860-5260 (KS only) or 1-316-337-7386	MISSOURI 1-800-390-3330	NORTHERN MARIANA ISLANDS 1-808-586-7299	TENNESSEE 1-800-525-2816 or 1-615-741-4955	

ealth Care Financing Administration (HCFA) Regional Offices: Call for information about local seminars and health fairs ☎
n Medicare health plan choices, or to report a complaint directly to HCFA.

If you live in:	The Regional Office is in:	The phone number is:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Boston	1-617-565-1232
New York, New Jersey, Puerto Rico, Virgin Islands	New York	1-212-264-3657
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Philadelphia	1-215-861-4226
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Atlanta	1-404-562-7500
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Chicago	1-312-353-7180
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Dallas	1-214-767-6401
Iowa, Kansas, Missouri, Nebraska	Kansas City	1-816-426-2866
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Denver	1-303-844-4024
American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands	San Francisco	1-415-744-3602
Alaska, Idaho, Oregon, Washington	Seattle	1-206-615-2354

Agencies On Aging: These agencies are responsible for coordinating services for older persons.

ALABAMA 1-800-243-5463	DISTRICT OF COLUMBIA 1-202-724-5622	KENTUCKY 1-502-564-6930	NEBRASKA 1-402-471-2306	OKLAHOMA 1-405-521-2327	VERMONT 1-802-241-2400
ALASKA 1-907-269-3680	FLORIDA 1-850-414-2000	LOUISIANA 1-504-342-7100	NEVADA 1-702-486-3545	OREGON 1-800-232-3020	VIRGINIA 1-804-662-9333
AMERICAN SAMOA 1-684-633-1252	GEORGIA 1-404-657-5258	MAINE 1-207-624-5335	NEW HAMPSHIRE 1-603-271-4680	PENNSYLVANIA 1-717-783-1550	VIRGIN ISLANDS 1-809-692-5950
ARIZONA 1-602-542-4446	GUAM 011-671-475-0263	MARYLAND 1-800-243-3425	NEW JERSEY 1-609-588-3139	PUERTO RICO 1-787-721-5710	WASHINGTON 1-360-586-8753
ARKANSAS 1-501-682-2441	HAWAII 1-808-586-0100	MASSACHUSETTS 1-617-727-7750	NEW MEXICO 1-505-827-7640	RHODE ISLAND 1-401-222-2858	WEST VIRGINIA 1-304-558-3317
CALIFORNIA 1-916-322-5290	IDAHO 1-208-334-2423	MICHIGAN 1-517-373-8230	NEW YORK 1-800-342-9871	SOUTH CAROLINA 1-803-253-6177	WISCONSIN 1-608-266-2536
COLORADO 1-303-620-4147	ILLINOIS 1-217-785-3356	MINNESOTA 1-800-882-6262	NORTH CAROLINA 1-919-733-3983	SOUTH DAKOTA 1-605-773-3656	WYOMING 1-307-777-7986
CONNECTICUT 1-800-443-9946	INDIANA 1-317-232-7020	MISSISSIPPI 1-601-359-4929	NORTH DAKOTA 1-800-755-8521	TENNESSEE 1-615-741-2056	
DELAWARE 1-800-223-9074	IOWA 1-515-281-5187	MISSOURI 1-573-751-3082	NORTHERN MARIANA ISLANDS 1-607-234-6011	TEXAS 1-512-424-6840	
	KANSAS 1-913-296-4986	MONTANA 1-406-444-7781	OHIO 1-614-466-5500	UTAH 1-801-538-3910	

Medicare Carriers: Call for questions on Part B coverage, bills, and medical services, or for information on how to recognize Medicare fraud and abuse. ☎

ALABAMA Blue Cross/Blue Shield of Alabama, 1-800-292-8855 or 1-205-988-2244	DELAWARE Medicare Customer Service Center, 1-800-444-4606	KANSAS Blue Cross/Blue Shield of Kansas, 1-800-432-3531 or 1-785-291-4000 (in Topeka) or 1-800-432-0216 (out of state)
ALASKA Blue Cross/Blue Shield of North Dakota, 1-800-444-4606	DISTRICT OF COLUMBIA Medicare Customer Service Center, 1-800-444-4606	KENTUCKY AdminaStar Federal, 1-800-999-7608 or 1-502-425-6759
AMERICAN SAMOA Blue Cross/Blue Shield of North Dakota, 1-800-444-4606	FLORIDA Blue Cross/Blue Shield of Florida, 1-800-333-7586 (FL only)	LOUISIANA Arkansas Blue Cross/Blue Shield, Inc., 1-800-462-9666 or Baton Rouge 1-504-927-3490
ARIZONA Blue Cross/Blue Shield of North Dakota, 1-800-444-4606	GEORGIA Cahaba, 1-800-727-0827 or 1-912-927-0934	MAINE National Heritage Insurance Company, 1-800-492-0919 or 1-781-741-5256
ARKANSAS Arkansas Blue Cross/Blue Shield, 1-800-482-5525 (AR only) or 1-314-212-1800	GUAM Blue Cross/Blue Shield of North Dakota, 1-800-444-4606	MARYLAND Medicare Customer Service Center, 1-800-444-4606
CALIFORNIA Transamerica Occidental Life Insurance, Counties of Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, & Santa Barbara 1-800-675-2266 (CA only) or 1-213-748-2311 Rest of State: National Heritage Insurance Company, 1-800-952-8627 or 1-530-743-1583	HAWAII Blue Cross/Blue Shield of North Dakota, 1-800-444-4606	MASSACHUSETTS National Heritage Insurance Company, 1-800-882-1228 or 1-781-741-5256
	IDAHO CIGNA Medicare, 1-800-627-2782 (ID only) or 1-615-244-5650	MICHIGAN Wisconsin Physicians Service (WPS) 1-800-482-4045
	ILLINOIS Wisconsin Physicians Service (WPS) 1-800-642-6930 or 1-312-938-8000 or TDD 1-800-535-6152	MINNESOTA United HealthCare Insurance Co., 1-800-352-2762 (MN only) or 1-612-884-7171
COLORADO Blue Cross/Blue Shield of North Dakota, 1-800-332-6681 or 1-303-831-2661	INDIANA AdminaStar Federal, 1-800-622-4792 or 1-317-842-4151	MISSISSIPPI United HealthCare Insurance, 1-800-682-5417 (MS only) or 1-601-956-0372
CONNECTICUT United HealthCare, 1-800-982-6819 (in CT only) or 1-203-237-8592	IOWA Wellmark Inc. Blue Cross/Blue Shield of Iowa, 1-515-245-4785 or 1-800-532-1285	MISSOURI Blue Cross/Blue Shield of Kansas (Kansas City area) 1-800-892-5900 or 1-816-561-0900; Arkansas Blue Cross/Blue Shield (rest of state) 1-800-322-6670 or 1-314-212-1800

Medicare Carriers: Call for questions on Part B coverage, bills, and medical services, or for information on how to recognize Medicare fraud and abuse.

MONTANA
Blue Cross/Blue Shield of Montana, 1-800-332-6146 (MT only) or 1-406-444-8350

NEBRASKA
Blue Cross/Blue Shield of Kansas, 1-800-633-1113

NEVADA
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

NEW HAMPSHIRE
National Heritage Insurance Company, 1-800-882-1228 or 1-781-741-5256

NEW JERSEY
Xact Medicare Service, 1-800-462-9306

NEW MEXICO
Arkansas Blue Cross/Blue Shield, 1-800-423-2925 or 1-505-872-2551

NEW YORK
Empire BC/BS: Bronx, Brooklyn, Columbia, Delaware, Dutchess, Greene, Manhattan, Nassau, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster & Westchester, 1-800-442-8430
Group Health Ins.: Queens, 1-212-721-1770
BC/BS of Western NY, 1-800-252-6550

NORTH CAROLINA
CIGNA, 1-800-672-3071 or 1-336-665-0348

NORTH DAKOTA
Blue Shield of North Dakota, 1-800-332-6681 or 1-800-247-2267 or 1-701-277-2363

NORTHERN MARIANA ISLANDS
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

OHIO
Nationwide Mutual Insurance Co., 1-800-282-0530 or 1-614-249-7157

OKLAHOMA
Arkansas Blue Cross/Blue Shield, 1-800-522-9079 or 1-405-848-7711

OREGON
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

PENNSYLVANIA
Xact Medicare Services, 1-800-382-1274

PUERTO RICO
Triple-S, Inc., 1-800-981-7015 in Puerto Rico
In a Metro Area, 1-787-749-4900

RHODE ISLAND
Blue Cross/Blue Shield of Rhode Island, 1-800-662-5170 (only in RI) or 1-401-861-2273

SOUTH CAROLINA
Blue Cross/Blue Shield of South Carolina, 1-800-868-2522 or 1-803-788-3882

SOUTH DAKOTA
Blue Cross/Blue Shield of North Dakota, 1-701-277-2363

TENNESSEE
CIGNA Medicare, 1-800-342-8900 (TN only) or 1-615-244-5650

TEXAS
Blue Cross/Blue Shield of Texas, 1-800-442-2620

UTAH
Blue Cross/Blue Shield of Utah, 1-800-426-3477 or 1-801-333-2430

VERMONT
National Heritage Insurance Company, 1-800-447-1142 or 1-781-741-5256

VIRGINIA
Medicare Customer Service Center-Counties of Arlington and Fairfax, 1-800-444-4606
United HealthCare (rest of state), 1-800-552-3423 or 1-804-330-4786

VIRGIN ISLANDS
Triple-S, Inc., 1-800-474-7448 (VI only)

WASHINGTON
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

WEST VIRGINIA
Nationwide Mutual Insurance Co., 1-800-848-0106 or 1-614-249-7157

WISCONSIN
Medicare/WPS, 1-800-944-0051 (WI only) or 1-608-221-3330 or TTY/TDD: 1-800-828-2837

WYOMING
Blue Cross/Blue Shield of North Dakota, 1-800-442-2371 or 1-307-632-9381

New Medicare Health Plan Choices

Congress passed a law in 1997 that made many changes in the Medicare program. The law includes a section called Medicare + Choice, which creates new health plan options. You can continue to receive Medicare benefits as you do now, or you may be able to change to a plan that gives you at least the same (possibly more) benefits. The choice is yours.

What are the Medicare Health Plans?

Medicare now offers more health plan choices in addition to the Original Medicare Plan. However, they all may not be available in your area. These choices may include:

Original Medicare Plan

The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan. Medicare pays its share of the bill and you pay the balance of the Medicare-approved payment amount.

Original Medicare Plan with a Supplemental Insurance (Medigap) Policy

The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan. You can buy one of ten standardized Medicare supplemental insurance policies (Medigap or Medicare SELECT). These policies provide extra benefits and help cover some of your out-of-pocket costs (see page 12).

Medicare Managed Care Plan

A Medicare Managed Care Plan is a group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Medicare Managed Care Plans include Health Maintenance Organizations (HMOs), Health Maintenance Organizations with a Point of Service option (HMOs With POS), Provider Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs).

Private Fee-for-Service Plan

A Private Fee-for-Service Plan is a private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much to pay for the services you receive. You may have extra benefits the Original Medicare Plan doesn't cover, but you may also face higher charges from doctors and other providers. This is not the same as the Original Medicare Plan.

New Medicare Health Plan Choices continued:

Medicare Medical Savings Account (MSA) Plan

This is a test program for approximately one percent (up to 390,000) of eligible Medicare beneficiaries. You choose a Medicare MSA health policy - a health insurance policy with a high deductible. Medicare pays the premium for the Medicare MSA health policy and makes a deposit to the Medicare MSA that you establish. You use the money deposited in your Medicare MSA to pay for medical expenses. If you don't use all the money in your Medicare MSA, next year's deposit will be added to your balance. Money can be withdrawn from a Medicare MSA for non-medical expenses, but that money will be taxed. If you enroll in a Medicare MSA Plan, you must stay in it for a full year. You can only sign up for a Medicare MSA Plan in November of each year, or during special enrollment periods. Under a Medicare MSA Plan, you may face higher charges from doctors and other providers than in the Original Medicare Plan.

Religious Fraternal Benefit Society Plans

These plans are offered by a Religious Fraternal Benefit Society for members of the society. Only members of the society may enroll. The society must meet Internal Revenue Service (IRS) and Medicare requirements for this type of organization. No other information on Religious Fraternal Benefit Society Plans is available at this time.

For more information about Medicare health plans:

- Look at a copy of the *Medicare & You 1999* handbook.
- This handbook can be found on the Internet at www.medicare.gov.
- Look at Medicare health plan comparison information on the Internet at www.medicare.gov. If you don't have a computer, your local library or senior center may be able to help you access the Medicare website.
- Ask for information on Medicare + Choice health plans available in your area by using the automated Medicare Special Information number at 1-800-318-2596.
- Call your State Health Insurance Assistance Program (see page 48).

* ACTIVITIES OF DAILY LIVING (ADL)	Activities you usually perform in the course of a normal day. Although definitions differ, ADL's are usually considered to be everyday activities such as walking, getting in and out of bed, dressing, bathing, eating, and toileting.
ASSIGNMENT	In the Original Medicare Plan, a process through which a doctor or supplier agrees to accept the amount Medicare approves as payment in full. (You must pay any coinsurance amount.)
BASIC BENEFITS	Benefits provided in Medigap Plan A. They are also included in all the other Medigap plans.
BENEFICIARY	A person who gets health care insurance through the Medicare program.
BENEFIT PERIOD	A way to measure your use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day you go to a hospital or skilled nursing facility. It ends after you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after 60 days, a new benefit period begins. Most Medicare Part A benefits are renewed. You must pay a new inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods a beneficiary can have. (See Lifetime Reserve Days.)
BENEFITS	The money or services provided by an insurance policy. In a health plan, benefits take the form of health care.
COINSURANCE	The percentage of the Medicare-approved charge that you have to pay; after you pay the Part A deductible; and after you pay the $100 deductible each year for Part B.
* CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1985	This law requires an employer to allow you to remain covered under the employer's group health plan for a certain length of time after losing your job or having your work hours reduced, or after your spouse's death or a divorce. However, you may have to pay both your share and the employer's share of the premium.
COORDINATION OF BENEFITS CLAUSE	A written statement that tells which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare plan, federal law may decide who pays first.
COPAYMENT	In some Medicare health plans, the amount that you pay for each medical service, like a doctor visit.

CREDITABLE COVERAGE	Any previous health insurance coverage that can be credited towards pre-existing condition restrictions.
CUSTODIAL CARE	Personal care such as bathing, cooking, shopping, etc.
DEDUCTIBLE	The amount you must pay before Medicare begins to pay; either each benefit period for Part A, or each year for Part B.
DISENROLL	End your health care coverage with a health plan.
DURABLE MEDICAL EQUIPMENT	Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Part B. You pay a 20% coinsurance payment.
* END-STAGE RENAL DISEASE (ESRD)	Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Medicare, and may be eligible for Social Security payments if found to be disabled.
* EXCESS CHARGE (MEDIGAP)	The difference between a doctor's or other healthcare provider's actual charge (up to the amount of charge limitation set by Medicare or the state) and the Medicare-approved payment amount.
EXCLUSION PERIOD	A period of time of up to 6 months when an insurance company can delay coverage of a pre-existing condition.
FISCAL INTERMEDIARY	A private company that has a contract with Medicare to pay bills for Part A hospital services.
GAPS	The costs or services that are not covered under the Original Medicare Plan.
GUARANTEED RENEWABLE	A Medigap policy that your insurance company must allow you to renew, unless you do not pay the premiums.
HEALTH CARE FINANCING ADMINISTRATION (HCFA)	The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Program, and works to make sure that the beneficiaries in these programs have access to high quality health care.
HOME HEALTH CARE	Medical care that is provided at home, such as physical therapy or skilled nursing care. It is different from at-home recovery care (see page 17) which is help with bathing, eating, and other activities of daily living. (See Activities of Daily Living.)
HOSPITAL INSURANCE (PART A)	Part of Medicare that covers inpatient hospital stay, skilled nursing facilities, home health care, and hospice care. (See Medicare Part A.)

LIFETIME RESERVE DAYS	60 lifetime days that Medicare will pay for when you are put in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($384 in 1999).
LIMITING CHARGE	The maximum amount doctors and other health care providers who don't accept assignment can charge you for a covered service. The limit is 15% over Medicare's approved payment amount.
LONG-TERM CARE	Custodial care provided at home or in a nursing home for people with chronic disabilities and prolonged illnesses. It is not covered by Medicare. You can buy long-term care insurance coverage from a private insurance company.
MEDICAID	A joint Federal and State program that helps with medical costs for some people with low incomes. Programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.
MEDICAL INSURANCE (PART B)	Part of Medicare that covers doctors' services, outpatient hospital care, and other medical services that Part A doesn't cover, such as the services of physical and occupational therapists. (See Medicare Part B.)
MEDICAL UNDERWRITING	The process that a company uses to determine whether or not to accept your application for insurance and how much to charge you for that insurance.
MEDICARE	A health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD), (people with permanent kidney failure who need dialysis or a transplant).
MEDICARE CARRIER	A private company that contracts with Medicare to process beneficiary bills (claims) for Part B services.
MEDICARE COVERAGE	Consists of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).
MEDICARE PART A (HOSPITAL INSURANCE)	Hospital insurance that pays for inpatient hospital stay, care in a skilled nursing facility, home health care, and hospice care. (See Hospital Insurance.)
MEDICARE PART B (MEDICAL INSURANCE)	Medical insurance that helps pay for doctors' services, outpatient care, and other medical services that are not covered by Part A. (See Medical Insurance.)

Glossary Of Terms

MEDICARE SELECT	A type of Medigap policy that must meet all of the requirements that apply to a Medigap policy. You may be required to use doctors and hospitals within its network in order to be eligible for full benefits.
MEDIGAP	A Medicare supplemental insurance policy that is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. There are ten standardized policies, labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.
OPEN ENROLLMENT (MEDIGAP)	A one-time only, six-month period after you enroll in Medicare Part B, and are 65 or older, when you can purchase any Medigap plan you want. You cannot be denied coverage due to your medical history during this time.
OUT-OF-POCKET COSTS	Health care costs that you must pay on your own because they are not covered by Medicare.
PRE-EXISTING CONDITION/MEDIGAP	Health problems that required medical treatment within the 6 months before the date that the policy went into effect.
PREMIUM	Periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.
PREVENTIVE CARE	Care to keep you healthy or prevent illness, such as routine checkups and some tests like colorectal cancer screening, yearly mammograms, and flu shots.
PRIMARY PAYER	The insurance company that pays first on a claim for medical care. This could be Medicare or other insurance.
PROTECTIONS AND GUARANTEES	Your rights to buy Medigap coverage in certain cases.
PROVIDER	A doctor, hospital, health care professional, or health care facility.
SECONDARY PAYER	The insurance company that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the circumstances.
SKILLED NURSING FACILITY (SNF)	A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.
WAITING PERIOD	The time between when you sign-up with a Medigap insurance company or Medicare health plan and when your coverage starts.

* This definition, whole or in part, was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology, 1997.

For Your Notes

For Your Notes

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, $300

Publication No. HCFA - 02110
Revised February 1999

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

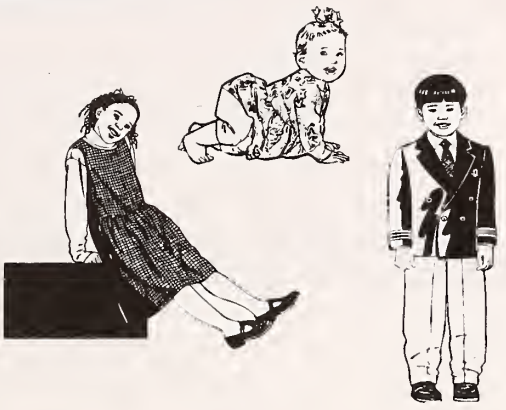
Audio tapes in English and Spanish, Braille in English, and Spanish copies of the *1999 Guide to Health Insurance for People with Medicare* are available (call 1-800-638-6833).

¿Necesita usted una copia en Español o en audio-cassette del manual de *La Guía de Seguro de Salud para personas con Medicare*? (Llame al 1-800-638-6833.)

New Health Insurance Is Now Available For:

- ✔ Infants
- ✔ Children
- ✔ Teens

Your children or grandchildren may qualify for free or low-cost health insurance.



Does your family have health insurance? There is a new program that can help working and non-working families get health insurance for their children (ages 0-19).

Health insurance helps pay for:

- Check-ups.
- Shots that protect children from some illnesses.
- Health care for illnesses and injuries.

Don't put it off . . .
tomorrow could be the day your children or grandchildren need insurance most.

For more information call:

1-877-KIDS-NOW

(1-877-543-7669)

This is a free call.

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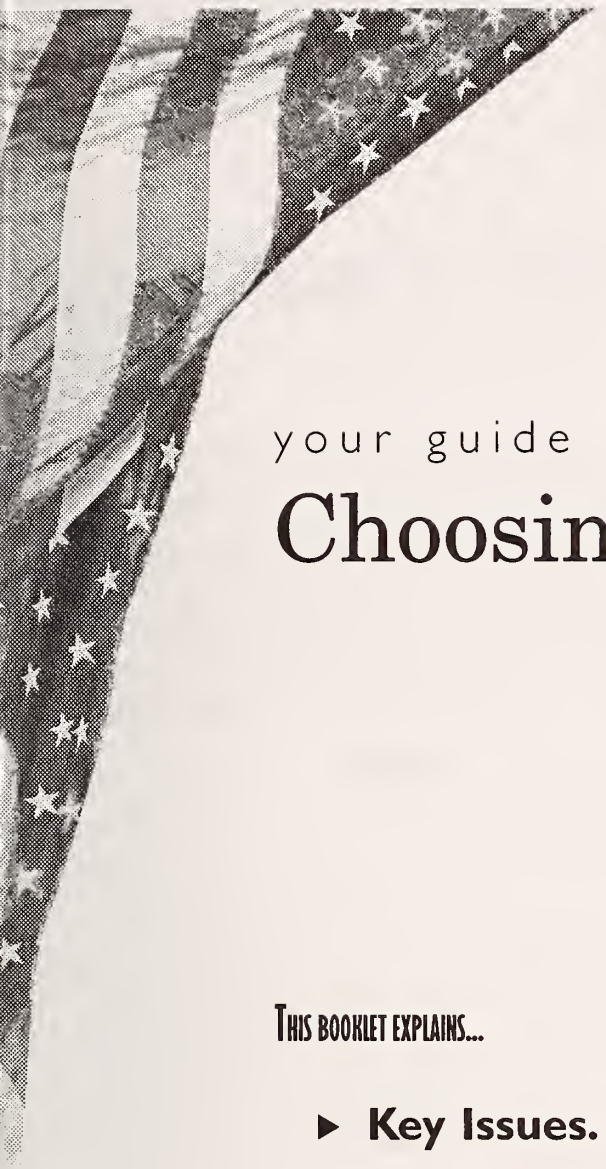

your guide to

Choosing a Nursing Home

THIS BOOKLET EXPLAINS...

- **Key Issues.**
- **Alternatives to Nursing Homes.**
- **Important Selection Factors.**
- **Nursing Home Resident Rights.**
- **Nursing Home Checklist.**
- **Sources of Help and Information.**

Health Care Financing Administration

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Publication No. HCFA–02174
August 1999

HCFA
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Health Care Financing Administration

READER NOTICE

The Health Care Financing Administration (HCFA) is the Federal Agency that oversees Medicare and Medicaid. Because most nursing home care is financed by Medicare or Medicaid, HCFA has to make sure nursing homes provide good care to residents. HCFA has a nursing home initiative which focuses on assuring quality care. This initiative has three parts: **education, empowerment, and enforcement** which are described below. This publication is designed to educate the reader about some important issues in nursing home care.

EDUCATION

Physical or chemical restraints on residents should be limited to circumstances where the resident's medical symptoms warrant them.

Residents must have enough of the right food and fluids to be healthy.

Resident abuse and neglect must not be tolerated.

EMPOWERMENT

Read admission agreements carefully and know your resident rights under Federal law.

Do not make a pre-payment or a cash deposit just to get into a nursing home if your care will be covered by Medicare or Medicaid.

Do not give up the right to apply for Medicare or Medicaid benefits or give up any transfer or discharge rights you may have.

ENFORCEMENT

When you see this symbol (☎), look in the back of this publication for the telephone number of agencies that work with HCFA to assure quality nursing home care. They can help you with questions or concerns you may have about nursing home care.

CONTENTS

INTRODUCTION

A nursing home is a residence that provides a room, meals, skilled nursing and rehabilitative care, medical services, and protective supervision to residents. It also provides residents with help with daily living and recreational activities. Many nursing home residents have physical, emotional or mental impairments which keep them from living independently. Nursing homes are certified by State and Federal government agencies to provide levels of care which range from custodial care to skilled nursing care that can only be delivered by trained professionals.

On any given day, nursing homes care for about one in twenty Americans over the age of 65.

Selecting a nursing home is one of the most important decisions that you may be asked to make. Depending on where you live, there may not be many choices in selecting a nursing home. This booklet outlines a step-by-step process that will help you compare nursing homes and make the best possible choice. This booklet also lists some key resources that will help you find the nursing home or long-term care facility that fits your needs.

If you must select a nursing home with little notice—during a family crisis or right after a serious illness, this publication should still give you valuable information about nursing homes and about the people who are able to help you if you have any concerns.

This publication is not a legal document. The official provisions of the Medicare and Medicaid programs are contained in the relevant laws, regulations, and rulings.

TALK TO PEOPLE #1

Before you begin to search for a nursing home, talk with people you trust and who can help you make a good choice. This group could include family and friends. It also could include a variety of health professionals like doctors, dietitians, social workers, and hospital discharge planners, who understand your special needs. Discuss your care needs and options with your group. They may be willing to help you.

If you are helping someone who is about to go into a nursing home, get them involved as much as possible. His or her wishes need to be respected. People who are involved from the beginning are better prepared when they move into a nursing home. If the person you are helping is not alert or able to communicate well, keep his or her values and preferences in mind. Finding a nursing home that provides the right services in a pleasant, comfortable atmosphere often requires work.

Ideally, you will have enough time to plan ahead, examine several nursing homes, and make good financial plans. Planning ahead gives you more control over the selection process, eases the stress of choosing a nursing home, and helps you make a good choice.

The likelihood of being a resident of a certified nursing home increases with age.

#2 LOOK AT OPTIONS

In most communities, people who cannot live independently may choose from a variety of living arrangements that offer different levels of care. Before deciding on a care setting, talk to a doctor or maybe a social worker about your care needs. Most people want to stay in their home for as long as possible. However, if you are considering staying at home, make sure you know the amount of responsibility and work involved. If you cannot live independently, but don't want to live in a nursing home, you may want to consider some of the alternatives listed below.

The Elder Care Locator can help you find necessary and convenient services that serve the elderly in their community.
1–800–677–1116

Home and Community Care

A person who is ill or disabled may be able to get help from a variety of home services that might make moving into a nursing home unnecessary. Home services include Meals on Wheels programs, friendly visiting and shopper services, and adult day care. These programs are found in most communities.

If you are considering home care, discuss this option with family members to learn if they are able to help provide your care or help arrange for other care providers to come to your home. Some nursing homes may provide respite care and admit a person in need of care for a short period of time to give the home care givers a break.

Depending on the case, Medicare, private insurance, and Medicaid may pay some home care costs that are related to medical care.

Subsidized Senior Housing (Non-Medical)

There are Federal and State programs that help pay for housing for older people with low to moderate

incomes. Some of these subsidized facilities offer assistance to residents who need help with certain tasks, such as shopping and laundry. Residents generally live independently in an apartment within the senior housing complex.

Assisted Living (Non-Medical Senior Housing)

If you only need help with a small number of tasks, such as cooking and laundry, or reminders to take medications, assisted living facilities may be an option worth considering. "Assisted living" is a general term for living arrangements in which some services are available to residents who still live independently within the assisted living complex. In most cases, assisted living residents pay a regular monthly rent, and then pay additional fees for the services that they require.

Usually, payment for assisted living care is not subsidized by other programs.

Board and Care Homes

Board and Care homes are group living arrangements designed to meet the needs of people who cannot live independently, but do not require nursing home services. These homes offer a wider range of services than independent living options. Most provide help with some of the activities of daily living, including eating, walking, bathing, and toileting. In some cases, private long-term care insurance and medical assistance programs will help pay for this type of living arrangement. Keep in mind that many of these homes do not get payment from Medicare or Medicaid and are not strictly monitored.

Continuing Care Retirement Communities (CCRCs)

CCRCs are housing communities that provide different levels of care based on the residents' needs from independent living apartments to skilled nursing care in an affiliated nursing home. Residents move from one setting to another based on their needs, but continue to remain a part of their CCRC community. Be sure to check the record of the CCRC's nursing home. Your CCRC contract usually will require you to use it. Many CCRCs require a large payment prior to admission and also charge monthly fees. For this reason, many CCRCs may be too expensive for older people with modest incomes.

Talk with people you trust before you make a decision about the type of care you may want.

Summary of Options

The options discussed in this chapter may work for people who require less than skilled care, or who require skilled care for only brief periods of time. Many people with long-term skilled care needs require a level and amount of care that cannot be easily handled outside of a nursing home.

GATHER INFORMATION

If you decide that a nursing home is the right choice, begin to gather information about the nursing homes in an area near your family and friends. The first step is to talk with your doctor or other health providers for suggestions. Then, look in the phone book. Your yellow pages list local nursing homes. Word of mouth can be a good source of information. Ask your friends and neighbors if they know people who have lived in local nursing homes. Also, your State or county Office on Aging (in the blue pages of your phone book) should have a listing of nursing homes in your area.

Nationwide, there are more than 600 Long-Term Care Ombudsman programs. They are a very good source of information and can be an important resource to nursing home residents, their families, and friends. Ombudsman volunteers visit nursing homes on a regular basis. They can provide information about how homes are organized and regulated. Ombudsmen should know about the strengths and weaknesses of nursing homes in their area. They can work to resolve problems such as poor care, dietary needs, and financial issues. Ombudsmen also can help you determine how problems in nursing homes can be best handled. (☎)

Although Ombudsman programs are not allowed to recommend one nursing home over another, they can provide the results of the latest State inspection on the home and some information about the nursing home's complaint history. Nursing home inspections are discussed in Chapter 6. Ombudsman programs can help explain any information that is not clear and

In 1999, there were about 16,000 certified nursing homes in the U.S. . . .

and 1.5 million people were living in them.

can give general advice on what to look for when visiting the various area nursing homes. (☎)

Another good source of information is the new ***Nursing Home Compare*** database at Medicare's Internet website **www.medicare.gov**. It gives you information about every Medicare and Medicaid certified nursing home in the country and the results from their latest nursing home inspection. You can search for nursing homes by geographic area and get a side-by-side comparison of important information like quality of care (bed or pressure sores are an example). The information is in an easy to read chart format. If you do not have a computer, your local library or senior center may be able to help you access the Internet.

EVALUATE FACTORS #4

The next step is to call the nursing homes on your list. Ask about the following factors. They are **very important** and can narrow your list of nursing homes.

Location

Location is very important. If you choose a nursing home that is close to your family and friends, they may be able to visit you more often, and you may feel less lonely. Also, they can act as your advocate (supporter) if you need one.

Availability

Nursing homes have a limited number of beds. When you find a nursing home you like, you should find out if there will be a bed available for you or if you can add your name to a waiting list. Although nursing homes do not have to accept all applicants for admission, they do have to comply with Civil Rights provisions that prohibit discrimination based on race, religion, etc.

On average, 8 out of 10 beds in certified nursing homes are occupied.

Staffing

It is important that the people who work in a nursing home are capable of performing their duties. This helps make sure that the residents are cared for and enjoy a good quality of life. Chapter 7 and the Check List in this publication have more detailed information.

Medicare and Medicaid

If you will be using Medicare or Medicaid to pay for your care, make certain that the nursing homes on your list accept Medicare or Medicaid payment. Often, a facility will set aside only a few beds for Medicare or Medicaid residents. Find out if the home will have

In 1996, nursing home expenditures were about $78.5 billion.

Medicare or Medicaid "beds" available when you need one. This is particularly important for people who change from paying privately to Medicaid during the course of their stay at a nursing home. When this happens, if "Medicaid" beds are not available, you may have to transfer to another facility. Even when Medicaid certified beds are available, under current law, a nursing home does not have to give one to a resident.

Services and Fees

The nursing home must inform you, in writing, about its services, charges, and fees before you enter the home. Most facilities charge a basic rate that covers room, meals, housekeeping, linen, general nursing care, recreation, and some personal care services. There may be extra charges for personal services, such as haircuts, manicures, and telephones. Get a copy of the fee schedule in advance so you can compare them with other homes.

Medicare beneficiaries pay coinsurance amounts and other charges for personal services when they become due. They do not pay before the service is given.

Religious and Cultural Preferences

Do the nursing homes on your list offer the type of religious and cultural environment that you prefer, including any special diets your faith practice may require?

Language

Do the staff and many of the residents speak your primary language? If not, you may not be able to communicate your needs and may feel lonely in the environment.

Special Care Needs

Are the nursing homes on your list able to provide care for any special medical condition you may need? Examples of medical conditions are dementia, End-Stage Renal Disease (ESRD), or Alzheimers.

#5 PAYING FOR CARE

For most people, finding ways to pay for nursing home care is a major concern because it is so expensive. There are several payment methods to consider.

Medicare

Under certain limited conditions, Medicare will pay some nursing home costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, you must receive the services from a Medicare certified skilled nursing home after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just prior to entering a nursing home. This is at least three days. To learn more about Medicare payment for skilled nursing home costs, contact your Medicare Fiscal Intermediary or the State Health Insurance Assistance Program (SHIP) in your State. (☎)

Medicaid is the primary payer for about 7 out of 10 nursing home residents.

Medicaid

Medicaid is a State and Federal program that will pay most nursing home costs for people with limited income and assets. Eligibility varies by State. Check your State's requirements to learn if you are eligible. Medicaid will pay only for nursing home care provided in a facility certified by the government to provide service to Medicaid recipients. For more information about Medicaid payments, call the SHIP for your State (☎) or call your State's Medicaid office. The telephone number is in the blue pages of the phone book.

In 1996, private payments for nursing home care were about $30.2 billion.

Personal Resources

About half of all nursing home residents pay nursing home costs out of their own savings. After these

savings and other resources are spent, many people who stay in nursing homes for long periods eventually become eligible for Medicaid.

Managed Care Plans

A managed care plan will not help pay for care unless the nursing home has a contract with the plan. If the home is approved by your plan, learn if the plan also monitors the home for quality of nursing care.

Medicare Supplemental Insurance

This is private insurance. It's often called Medigap because it helps pay for gaps in Medicare coverage such as deductibles and co-insurances. Most Medigap plans will help pay for skilled nursing care, but only when that care is covered by Medicare. Some people use employer group health plans or long-term care insurance to help cover nursing home costs.

Long-Term Care Insurance

This is a private policy. The benefits and costs of these plans vary widely. For more information on these plans, contact the National Association of Insurance Commissioners (NAIC). It represents state health insurance regulators and has a free publication called *A Shopper's Guide to Long-Term Care Insurance*. You also can get a copy of the *Guide to Health Insurance for People with Medicare* by calling 1-800-MEDICARE.

Counseling and Assistance

SHIPs (☎) have counselors who might be able to answer your questions about how to pay for nursing home care, the coverage you may already have, or whether there are any government programs that will help with your expenses.

Write to the NAIC:
Publications Department
120 West 12th Street
Suite 1100
Kansas City, MO 64105

The number for the Medicare toll free line is **1-800-633-4227**.

If you use a TTY/TDD line, the telephone number is 1-877-486-2048.

#6 VISIT NURSING HOMES

The nursing home visit is a very important step in selecting the right nursing home for you. A visit gives you an opportunity to talk with nursing home staff and, more importantly, with the people who live and receive care at the nursing home.

When you visit the nursing home, you will probably be given a formal tour. This is a useful introduction to the home, but it is important that you are not overly influenced by a guided tour. Use this time to evaluate the overall atmosphere of the home.

Tip

The Check List at the end of this publication will give you some more ideas on questions to ask.

When the tour is over, tell the nursing home staff you may want to return, but don't want another formal tour. Get some suggestions of different times of the week and day to visit. This should give you a complete picture of the services and activities available to residents. When you return, make sure to check with nursing home staff before entering resident care areas. Respect resident privacy when walking around.

The Nursing Home Inspection

Tip

See *Nursing Home Compare* at **www.medicare.gov** for help.

Near the end of your visit, ask to see a copy of the nursing home's most recent inspection. An inspection is a written report that says how well the nursing home meets Federal health and safety requirements. This report is like a snapshot. It shows what deficiencies were found at the time of the inspection. Deficiencies are rated on scope and severity. Scope tells you how often a certain problem occurs. Severity tells you how seriously the problem impacts the health and safety of residents.

Nursing homes are inspected about every nine to fifteen months. Usually this is done by employees of the State where the nursing home is located. Nursing

homes that do not meet State and Federal requirements are subject to fines and other penalties if their deficiencies are not corrected. By law, the nursing home inspection report must be posted in an area that is convenient for residents and their visitors to see. (☎)

Quality of Life

The law requires that residents receive the necessary care and services that will enable them to reach and maintain their highest practicable level of physical, mental, and social well-being. In the last decade, different laws and regulations also have been passed to raise the quality of life and standards of care for nursing home residents.

Nursing home residents rate the way they are treated by staff as an important factor in their happiness.

When considering a nursing home, it is important to remember that people who are admitted into nursing homes do not leave their personalities at the door. They keep life-long preferences and habits. They still have the basic human need for respect, encouragement, and friendship.

To maintain a good quality of life, nursing home residents:

- Need to keep as much control over the events in their daily lives as possible. People can become very depressed when these basic decisions are made by others or life-long patterns are changed.
- Should have the freedom and privacy to attend to their personal needs, to participate in their care planning, and to examine their medical records.

- May only be restrained to treat medical symptoms if using them is reflected in the resident's comprehensive assessment and care plan. Benefits from using restraints should outweigh the risks of harm to the resident.

When you visit a nursing home, keep these questions in mind.

- Does the interaction between residents and the staff seem warm and friendly?
- Most residents must share their room. Do residents have a reasonable choice of roommates? How are differences between roommates resolved?
- Even though space in nursing homes is limited, having a few cherished items can be very comforting. How does the home help protect resident's property and personal items?
- Does the nursing home provide a variety of activities that residents like and allow residents to choose the activities they want to attend? Are there activities for bed-bound patients?
- Are family members encouraged to visit, and are they encouraged to bring special ethnic or religious foods on special or holy days?

Tip

Use the tips in the Quality of Life section of the Check List to help you evaluate the nursing home.

Quality of Care

By law, nursing homes must make a thorough assessment of every new resident within two weeks of admission. The assessment covers important issues like the resident's mobility, skin condition, nutritional

and medical status, rehabilitation needs, and daily habits.

Based upon the assessment, the home also must complete a resident care plan that helps each resident reach or keep his or her highest level of well-being. Good care plans are put together by a variety of health care providers as well as the resident, and family and friends. Care plans may change as a resident's needs change.

Tip

Care plan meetings should be held at times when it is easy for family and friends to attend.

Unless you have a medical or social work background, it might be difficult to assess the quality of health care the nursing home provides to its residents. However, that does not mean you cannot trust your senses: does the home look and smell clean, is it pleasantly lit, do residents seem relaxed, and do staff seem to respond quickly to call lights for help?

Other ways to evaluate the home are:

- Check the most recent State inspection report. If the home was cited for deficient practices in any quality of care areas, ask staff how they were corrected. (☎)
- Learn if the home has written policies to prevent resident abuse and neglect.
- Does there seem to be enough staff to care for the number of residents.
- Find out how long the current staff have been working at the home.
- If you have special needs (dementia, permanent kidney disease, ventilator dependency), make sure the home has experience in working with people who have had the same condition.

Tip

See Nursing Home Compare at **www.medicare.gov** for help.

Even if you have a trusted doctor, ask how often the nursing home's Medical Director visits the home. You should be confident that the home's Medical Director can take care of resident needs, because he or she might be called in emergencies.

Nutrition and Hydration

Weight loss is not a normal process of aging.

Lack of proper nutrition, or malnutrition, can be a serious health problem for older people. This problem is more than not getting enough to eat. It also can mean not getting enough vitamins and minerals in your food or not being able to process food after eating.

There are different reasons for malnutrition. Some people just cannot feed themselves and the nursing home does not have enough staff to help them eat. Poor dental health can make eating difficult. Another reason for malnutrition is that people begin to lose their sense of taste and smell around 60 years of age. If food doesn't taste or smell good, people may not feel like eating. Whatever the reason, the effects of malnutrition can lead to confused thinking, a reduced resistance to illness or the ability to recover from illness, and reduced physical ability.

Tip

Use the tips under nutrition in the Check List to help you evaluate the home.

Dehydration is another serious health problem for many older people who may take multiple prescription drugs that dry out their bodies. Also, older people may drink less because:

- They have a decreased sense of thirst and just do not feel thirsty;
- They want to avoid going to the bathroom as often if moving about is difficult for them; or

- They do not get help quickly enough to get to the bathroom and are afraid of incontinence.

Not getting enough fluids is dangerous. It can make people more vulnerable to illness and problems like low blood pressure, dizziness, and confusion. Dehydration can even lead to hospitalization.

The Nursing Home Check List

As you visit several homes, it might become difficult to keep all of your observations straight. In the back of this publication you will find a nursing home Check List. Make copies of this Check List and fill out a separate Check List for every nursing home that you visit. Do this during or right after the visit while your memory is fresh.

After visiting several homes and filling out the Check List, you should be ready to decide on some homes that might be a good choice for you or the person you are helping. When you narrow your list down to a small number, it is time to conduct follow-up visits.

#7 FOLLOW-UP VISITS

You should visit the nursing homes on your list as many additional times as you think necessary. Make sure that you see the home at least once in the evening and on a weekend because staffing and care giving is frequently different at these times. You may want to take the time to get a copy of the nursing home's admission or contract agreements.

Every nursing home should have an admission contract or agreement. Read them carefully. They should not have any statements that make residents give up their rights. Resident rights are described in Chapter 8.

Tip

Resident and family councils must be free to act independently from the nursing home's management.

Also, it would be helpful if your follow-up visit included attending a meeting of the nursing home's resident council or family council. Resident and family councils play an active role in promoting quality of life for nursing home residents. Ask if you may attend a meeting or read the minutes from a meeting. They could give you a point of view from the nursing home staff and a closer look at the concerns of the residents or their families.

After your follow-up visits, if it is still difficult to decide upon a nursing home, call the Ombudsman (☎) and the other people who provided you with information and help in the past. If you have any additional questions, do not hesitate to contact or visit the nursing home again.

It is possible that more than one nursing home will be a good choice, but you now should have enough information to be confident that you are making a well-informed choice.

AFTER ADMISSION #8

New nursing home residents may go through a difficult adjustment period, even if the nursing home is doing all that it can. The adjustment can be made easier with the support of family and friends. The adjustment also can be made easier by knowing about your resident rights and some special protections under the law.

Respect

Nursing home residents have the right to be treated with dignity and respect. As long as it fits your plan of care, you have the right to make your own schedule, including when you go to bed, rise in the morning, and eat your meals. You have the right to select the activities you would like to attend. You also may have the right to leave the facility with relatives or friends after notifying the staff.

Restraints

It is against the law for a nursing home to use physical and chemical restraints, except when necessary, to treat medical symptoms. Restraints may not be used for discipline or for the convenience of the nursing home staff.

Restrained residents may have decreased functional ability, lower self-esteem and feel depressed or angry. Restraints do not provide security or safety. Residents also are likely to be seriously injured if they fall with a restraint on. A physician must provide medical orders for any use of restraints and give the reason why they are needed except in certain emergency circumstances.

Tip

Set up a filing system to keep track of papers and information about residents' rights, admission and transfer policies, and any other information the home provides.

Managing Money

You have the right to manage your own money or to pick someone you trust to do so. If you request the nursing home to manage your personal funds, you must sign a written statement that authorizes the nursing home to do this for you. However, the nursing home must allow you access to your bank accounts, cash, and other financial records. The nursing home must protect your funds from any loss by purchasing a bond or providing other similar assurances.

Try to extend homeowner or other policies to include resident's belongings.

Privacy, Property, and Living Arrangements

You have the right to privacy. In addition, you have the right to keep and use your personal property, as long as it does not interfere with the rights, health or safety of others. Your mail should never be opened by the home unless you allow it. The nursing home must have a system in place to keep you safe from neglect and abuse, and to protect your property from theft. See if there is a safe in the facility or cupboards with locked doors in resident rooms. If you and your spouse live in the same home, you are entitled to share a room (if you both agree to do so).

Make an inventory of things you bring into the home (including eyeglasses and dentures). Update it regularly.

Guardianship and Advance Directives

As a nursing home resident, you are responsible for making your own decisions (unless you are mentally unable or have made legal arrangements for help). You may also draw up a document called an Advance Directive. This sometimes is called a living will because it becomes effective while you are still alive. It is a legal document that says what type of treat-

ment you want or don't want in case you cannot speak for yourself.

If you wish, you may designate someone else to make health care decisions for you. This is called a Durable Power of Attorney for health care. The person you name will become your legal guardian if you ever become incapable of making your own decisions. Depending upon your State's laws, you may need a lawyer to draw up a Durable Power of Attorney order or a living will. Although the nursing home should be able to help you with this, other help is available.

Check with your State Health Insurance Assistance Program (SHIP) (☎) or with the local Office on Aging to find out if your State has any legal assistance services that help with preparing these documents. You will find the phone number for your local Office on Aging in the blue pages of your phone directory.

Visitors

You have the right to spend private time with visitors at any reasonable hour. You have the right to make and receive telephone calls in privacy. The nursing home must permit your family to visit you at any time, as long as you wish to see them. You do not have to see any visitor you do not wish to see. Any person who provides you with health or legal services may see you at any reasonable times.

Medical Care

You have the right to be informed about your medical condition, medications, and to participate in developing your Plan of Care. You have the right to examine your medical records and reports upon request. You

Tip

Get a copy of the care plan and the name of the staff who helped create it.

have the right to refuse medications or treatments, and to see your own doctor.

Social Services

The nursing home must provide each resident with any needed social services, including counseling, mediation of disputes with other residents, assistance in contacting legal and financial professionals, and discharge planning.

Moving Out

Living in a nursing home is voluntary. You are free to move to another place. However, nursing home admission policies usually require that you give proper notice that you are leaving. If you do not give proper notice, you may owe the nursing home money based on the home's proper notice rules. If you are going to another nursing home, make sure the home has a bed for you.

Discharge and Transfer

Whether leaving a room or the nursing home, change can be very traumatic for residents. Nursing homes cannot discharge you unless:

- It is necessary for the welfare, health, or safety of you or others;
- Your health has declined to the point that the nursing home cannot meet your care needs;
- Your health has improved to the point that nursing home care is no longer necessary;

- The nursing home has not been paid for services you received; or
- The nursing home closed.

Except in emergencies, the facility must give a 30 day written notice of discharge or transfer. Residents have the right to appeal a transfer to another facility.

Rights for Families and Friends

Relatives and friends have rights too. Family members and legal guardians have the right to privacy when visiting the nursing home when the resident asks. They also have the right to meet with the families of other residents and to join or address family councils.

By law, nursing homes must develop a plan of care for every resident. Family members are allowed to participate in the development of the care plan with the resident's permission. Relatives who have legal guardianship of nursing home residents have the right to examine all medical records concerning their loved one and the right to make important decisions on his or her behalf.

Family and friends can make sure the resident receives good care. They visit often, know the nursing home's staff and procedures, express concerns to the right staff member, and are active in the nursing home's family council.

Although there are people in the nursing home who may be able to help, if the home does not address your concerns or complaints, call the State's inspection agency or the Long-Term Care Ombudsman. (☎)

Tip

Your local Long-Term Care Ombudsman program can help with any concerns or questions you have about nursing homes. ☎

Family and resident councils provide a strong unified voice for resident concerns.

IMPORTANT NUMBERS

The programs and agencies listed below can help you. Call the Long-Term Care Ombudsman to get help with a complaint about quality of care or life in a nursing home and to get help in mediating a dispute with a nursing home. Call the State to get information about the latest State inspection on nursing homes or to file a complaint against a nursing home. Call the State Health Insurance Assistance Program (SHIP) to get general information about Medicare benefits and programs.

Calls made to the toll free numbers should be free when made within the respective State. The telephone numbers in this section were correct when published. Check the Internet (www.medicare.gov) for current telephone numbers.

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Alabama	1-334-242-5743 1-800-243-5463	1-334-206-5075 1-800-356-9596 * 1-800-855-1155 TDD	1-334-242-5743 1-800-243-5463 * 1-334-242-0995 TDD
Alaska	1-907-563-6393 1-800-730-6393 *	1-907-561-8081	1-907-269-3680 1-800-478-9996 *
American Samoa	1-808-586-0100 1-800-999-4454	1-808-692-7420 1-800-468-4644 * 1-800-586-4648 TDD	1-808-586-7299
Arizona	1-602-542-4446 1-800-432-4040 1-602-542-6435 TDD	1-602-674-9705	1-602-542-6595 1-800-432-4040 1-602-542-6366 TDD
Arkansas	1-501-682-2441 1-501-682-2443 TDD	1-501-661-2000 1-800-482-5400 1-501-661-2328 TDD	1-501-371-2782 1-800-224-6330

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
California	1-916-323-6681 1-800-231-4024	1-916-445-2070 1-800-236-9747 1-800-735-2929 TDD	1-916-323-7315 1-800-434-0222 1-800-735-2929 TDD
Colorado	1-303-722-0300 1-800-288-1376	1-303-692-2800 1-808-886-7689 *	1-303-894-7499 ext. 356 1-800-544-9181 1-303-894-2900 ext. 833 TDD
Connecticut	1-860-424-5200	1-860-509-7400 1-860-509-7191 TDD	1-860-424-5245 1-800-994-9422 * 1-860-842-5424 TDD
Delaware	1-302-577-4791 1-800-223-9074	1-302-577-6666	1-302-739-6266 1-800-336-9500 *
District of Columbia	1-202-434-2190	1-202-442-5888	1-202-676-3900
Florida	1-850-488-6190 1-800-511-7023	1-850-488-1295	1-850-414-2060 1-800-963-5337 * 1-850-414-2001 TDD
Georgia	1-404-657-5334 1-800-669-8387	1-404-657-5850	1-404-657-5334 1-800-669-8387 *
Guam	1-808-586-0100 1-800-999-4454 *	1-671-475-0262	1-808-586-7299

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Hawaii	1-808-586-0100 1-800-999-4454 *	1-808-692-7420 1-800-468-4644 *	1-808-586-7299
Idaho	1-208-334-4693	1-208-334-6626	1-208-334-4350 1-800-247-4422 * 1-800-377-3529 TDD
Illinois	1-217-524-6837 1-800-252-8966 *	1-217-782-5180 1-800-252-4343 *	1-217-785-9021 1-800-548-9034 * 1-217-524-4872 TDD
Indiana	1-317-232-7134 1-800-545-7763	1-317-233-7442 1-800-246-8909	1-317-233-3475 1-800-452-4800
Iowa	1-515-281-5426 1-800-532-3213 * 1-515-281-5188 TDD	1-515-281-4115 1-515-242-6515 TDD	1-515-281-6867 1-800-351-4664
Kansas	1-785-296-3017 1-877-662-8362	1-785-296-1240 1-800-842-0078 *	1-316-337-7386 1-800-860-5260 * 1-877-235-3151 TDD
Kentucky	1-502-564-6930 1-800-372-2991 1-888-642-1137 TDD	1-502-564-2800	1-502-564-7372 1-502-564-0126 TDD
Louisiana	1-225-342-7100	1-225-342-0148	1-225-342-0825 1-800-259-5301 *
Maine	1-207-621-1079 1-800-499-0229 * TDD	1-207-624-5443	1-207-623-1797 1-800-750-5353

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Maryland	1-410-767-1091 1-800-243-3425 * 1-410-767-1083 TDD	1-410-764-2750 1-800-492-6005 1-800-735-2258 TDD	1-410-767-1100 1-800-243-3425 * 1-410-767-1083 TDD
Massachusetts	1-617-727-7750 1-800-882-2003 1-800-872-0166 TDD	1-617-753-8000	1-617-727-7750 1-800-882-2003 * 1-800-872-0166 TDD
Michigan	1-517-886-6797 1-800-292-7852 *	1-517-334-8408 1-800-882-6006 *	1-517-373-8230 1-800-803-7174 1-517-373-4096 TDD
Minnesota	1-651-296-0382 1-800-657-3591 1-800-627-3529 TDD	1-651-215-8700 1-800-369-7994 1-651-297-5353 TDD	1-651-333-2433 1-800-333-2433 1-800-627-3529 TDD
Mississippi	1-601-359-4929 1-800-948-3090	1-601-354-7300 1-800-227-7308	1-601-359-4929 1-800-948-3090
Missouri	1-573-526-0727 1-800-309-3282 1-800-735-2966 TDD	1-573-751-6302	1-573-893-7900 ext. 300 1-800-390-3330
Montana	1-406-444-4676 1-800-332-2272 *	1-406-444-2099	1-406-444-7781 1-800-332-2272 * 1-800-833-8503 TDD
Nebraska	1-402-471-2307 1-800-942-7830 *	1-402-471-4961 1-402-471-9570 TDD	1-402-471-2201 1-800-234-7119 1-800-833-7352 TDD

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Nevada	1-775-486-3545 1-800-992-0900 * ext. 3545 1-775-486-3236 TDD	1-775-687-4475 1-800-225-3414	1-775-486-3478 1-800-307-4444
New Hampshire	1-603-271-4375 1-800-442-5640 * 1-800-735-2964 TDD	1-603-271-4592 1-800-852-3345 *	1-603-225-9000 1-800-852-3388 *
New Jersey	1-609-588-3146 1-800-792-8820 *	1-609-292-7834 1-800-367-6543 *	1-609-588-3139 1-800-792-8820 *
New Mexico	1-505-827-7640 1-800-432-2080 *	1-505-827-4200 1-800-752-8649 *	1-505-827-7640 1-800-432-2080 *
New York	1-518-474-0180 1-800-342-9871 *	1-518-474-6630 1-800-342-3736 *	1-212-869-3850 1-800-333-4114
North Carolina	1-919-733-8395 1-800-662-7030 *	1-919-733-7461 1-800-624-3004 *	1-919-733-0111 1-800-443-9354 * 1-919-715-0319 TDD
North Dakota	1-701-328-8934 1-800-755-8521	1-701-328-2352 1-701-328-2068 TDD	1-701-328-2440 1-800-247-0560 * 1-800-366-6888 TDD
N. Mariana Islands	1-808-586-0100 1-800-999-4454 *	1-808-586-4080 1-800-468-4644 1-800-586-4684 TDD	1-808-586-7299

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Ohio	1-614-644-7922 1-800-282-1206 1-614-466-6191 TDD	1-614-752-9524 1-800-342-0553 * 1-614-752-9172 TDD	1-614-644-3458 1-800-686-1578 *
Oklahoma	1-405-521-6734	1-405-271-6868 1-800-234-7258 *	1-405-521-6628 1-800-763-2828 *
Oregon	1-503-378-6533 1-800-522-2602 *	1-503-945-5832 1-800-232-3020 * 1-503-954-5832 TDD	1-503-947-7984 1-800-722-4134 1-503-954-5832 TDD
Pennsylvania	1-717-783-1550	1-717-787-1816 1-800-254-5164	1-717-783-8975 1-800-783-7067
Puerto Rico	1-787-725-1515	1-787-782-0120 1-800-981-8666	1-787-721-8590 1-877-725-4300 *
Rhode Island	1-401-785-3340	1-401-222-2566	1-401-222-2880 1-800-322-2880 *
South Carolina	1-803-898-2850 1-800-868-9095 *	1-803-737-7205 1-800-922-6735 *	1-803-898-2850 1-800-868-9095 *
South Dakota	1-605-773-3656	1-605-773-3356	1-605-773-3656 1-800-822-8804
Tennessee	1-615-741-2056 1-800-848-0298 TDD	1-615-862-5900	1-615-741-4955 1-800-525-2816

* In-state only

State	Long-Term Care Ombudsman	State Survey Agency	State Health Insurance Assistance Program
Texas	1-512-424-6840 1-800-252-2412	1-512-834-6650 1-800-228-1570	1-512-424-6840 1-800-252-9240
Utah	1-801-538-3910 1-800-541-7735 *	1-801-538-6559 1-800-999-7339 *	1-801-538-3910 1-800-541-7735 *
Vermont	1-802-863-5620 1-800-747-5022 *	1-802-241-2345 1-800-564-1612	1-802-748-5182 1-800-642-5119 *
Virgin Islands	1-787-725-1515	1-340-774-2991	1-340-778-6311 ext.2338
Virginia	1-804-644-2804 1-800-552-3402 *	1-804-367-2100 1-800-955-1819 1-804-828-1120 TDD	1-804-662-9333 1-800-552-3402
Washington	1-800-562-6028	1-360-705-6655 1-360-664-0064 TDD	1-360-407-0383 1-800-397-4422 * 1-360-493-2637 TDD
West Virginia	1-304-558-3317	1-304-558-0050 1-800-442-2888 *	1-304-558-3317 1-877-987-4463
Wisconsin	1-608-266-7159 1-800-815-0015	1-608-266-8481 1-800-642-6552 * 1-800-947-3529 TDD	1-608-266-2536 1-800-242-1060
Wyoming	1-307-322-5553 1-307-635-1245	1-307-777-7123 1-307-777-5648 TDD	1-307-856-6880 1-800-856-4398

* In-state only

CHECK LIST

Check lists can help you evaluate the nursing homes that you visit. Use a new check list for each home you visit. Then, compare the lists. This will help you select a nursing home that is a good choice for you or your relative.

FACILITY NAME: _____ **DATE VISITED:** _____

ADDRESS: _____

I. Basic Information

	YES	NO
1. Medicare Certified	☐	☐
2. Medicaid Certified	☐	☐
3. Accepting New Patients	☐	☐
4. Waiting Period for Admission	☐	☐

5. Number of Beds in each category available to you _____

USEFUL TIPS

- Generally, skilled nursing care is available only for a short period of time after a hospitalization. Basic nursing care is for a much longer period of time. If a facility offers both types of care, learn if residents may transfer between levels of care within the nursing home without having to move from their old room or from the nursing home.
- Nursing homes that only take Medicaid residents might offer longer term but less intensive levels of care. Homes that do not accept Medicaid payment may make a resident move when Medicare or the resident's own money runs out.
- An occupancy rate is the total number of residents currently living in a nursing home divided by the home's total number of beds. Occupancy rates vary by area, depending on the overall number of available nursing home beds.

II. Nursing Home Information

	YES	NO
1. The home and the current administrator are licensed	☐	☐
2. The home conducts background checks on all staff	☐	☐
3. The home has Special Services Units	☐	☐
4. The home has Abuse Prevention Training	☐	☐

Useful Tips

- **LICENSURE:** The nursing home and its administrator should be licensed by the State to operate.
- **BACKGROUND CHECKS:** Do the nursing home's procedures to screen potential employees for a history of abuse meet your State's requirements? Your State's Ombudsman program might be able to help you with this information.
- **SPECIAL SERVICES:** If a nursing home has special service units, learn if there are separate waiting periods or facility guidelines for when residents would be moved on or off the special unit. Some examples are: rehabilitation, Alzheimers, and hospice.
- **STAFF TRAINING:** Do the nursing home's training programs educate employees about how to recognize resident abuse and neglect, how to deal with aggressive or difficult residents, and how to deal with the stress of caring for so many needs? Are there clear procedures to identify events or trends that might lead to abuse and neglect, and on how to investigate, report, and resolve your complaints?
- **LOSS PREVENTION:** Are there policies or procedures to safeguard resident possessions?

For Parts three through six, give the nursing home a grade from one to five. One is poor, five is best.

III. Quality of Life

		GRADE				
		POOR				BEST
1.	Residents can make choices about their daily routine. Examples are when to go to bed or get up, when to bathe, or when to eat.	1	2	3	4	5
2.	The interaction between staff and patient is warm and respectful.	1	2	3	4	5
3.	The home is easy to visit for friends and family.	1	2	3	4	5
4.	The nursing home meets your cultural, religious, or language needs.	1	2	3	4	5
5.	The nursing home smells and looks clean and is well-lighted.	1	2	3	4	5
6.	The home maintains comfortable temperatures.	1	2	3	4	5
7.	The resident rooms have personal articles and furniture.	1	2	3	4	5
8.	The public and resident rooms have comfortable furniture.	1	2	3	4	5
9.	The nursing home and its dining room are generally quiet.	1	2	3	4	5
10.	Residents may choose from a variety of activities that they like.	1	2	3	4	5
11.	The nursing home has outside volunteer groups.	1	2	3	4	5
12.	The nursing home has outdoor areas for resident use and helps residents to get outside.	1	2	3	4	5

TOTAL _____

IV. Quality of Care

		GRADE				
		Poor				Best
1.	The facility corrected any Quality of Care deficiencies that were in the State inspection report.	1	2	3	4	5
2.	Residents may continue to see their personal physician.	1	2	3	4	5
3.	Residents are clean, appropriately dressed, and well groomed.	1	2	3	4	5
4.	Nursing home staff respond quickly to calls for help.	1	2	3	4	5
5.	The administrator and staff seem comfortable with each other and with the residents.	1	2	3	4	5
6.	Residents have the same care givers on a daily basis.	1	2	3	4	5
7.	There are enough staff at night and on weekends or holidays to care for each resident.	1	2	3	4	5
8.	The home has an arrangement for emergency situations with a nearby hospital.	1	2	3	4	5
9.	The family and residents councils are independent from the nursing home's management.	1	2	3	4	5
10.	Care plan meetings are held at times that are easy for residents and their family members to attend.	1	2	3	4	5

Total _____

Useful Tips

- A good patient/staff ratio is important to good care, but you should also consider other care factors. Examples are staff training programs and how long staff stay at the home. If staff changes frequently, ask why.
- Good care plans are essential to good care. They should be put together by a team of providers and family and updated as often as necessary.

V. Nutrition and Hydration

		GRADE				
		Poor				Best
1.	The home corrected any deficiencies in these areas that were on the recent survey.	1	2	3	4	5
2.	There are enough staff to assist each resident who requires help with eating.	1	2	3	4	5
3.	The food smells and looks good and is served at proper temperatures.	1	2	3	4	5
4.	Residents are offered choices of food at mealtimes.	1	2	3	4	5
5.	Residents' weight is routinely monitored.	1	2	3	4	5
6.	There are water pitchers and glasses on tables in the rooms.	1	2	3	4	5
7.	Staff encourage residents to drink if they are not able to do so on their own.	1	2	3	4	5
8.	Nutritious snacks are available during the day and evening.	1	2	3	4	5
9.	The dining room environment encourages residents to relax, socialize, and enjoy their food.	1	2	3	4	5
		Total	_____			

Useful Tips

- Ask the professional staff how the medicine a resident takes can effect what they eat and how often they may want something to drink.
- Visit at meal time. Are residents rushed through meals or do they have time to finish eating and to use the meal as an opportunity to socialize with each other?
- Sometimes the food a home serves is fine, but a resident still will not eat. Like everyone, nursing home residents like some control over their diet. Can they select their meals from a menu or select their mealtime?
- If residents need help eating, do care plans specify what type of assistance they will receive?

VI. Safety	GRADE Poor				Best
1. There are handrails in the hallways and grab bars in the bathrooms.	1	2	3	4	5
2. Exits are clearly marked.	1	2	3	4	5
3. Spills and other accidents are cleaned up quickly.	1	2	3	4	5
4. Hallways are free of clutter and well-lighted.	1	2	3	4	5
5. There are enough staff to help move residents quickly in an emergency.	1	2	3	4	5
6. The nursing home has smoke detectors and sprinklers.	1	2	3	4	5

Total _____

Facility Total _____

Other Observations:

DEFINITIONS

ABUSE The willful infliction of injury, unreasonable confinement, intimidation, or punishment with physical harm, pain, or mental anguish.

ASSESSMENT The rating or evaluation of a resident's health status and needs while they are in a nursing home.

CARE PLAN A written strategy that states what services a resident will receive to reach and keep their best possible physical, mental, and psychosocial well being.

DEFICIENCY A way to show that a nursing home failed to meet one or more Federal or State requirements.

DEHYDRATION A serious condition where a body's loss of fluids is more than the amount of fluid taken into the body.

MALNUTRITION A condition caused by the lack (or too much) of essential nutrients.

MEDIATE To settle differences between two or more parties.

NEGLECT Failure to provide goods or services that are necessary to avoid physical harm or mental anguish or illness.

LONG-TERM CARE OMBUDSMAN A supporter for nursing home residents who works to resolve problems between residents and nursing homes.

RESPITE CARE Care given to a nursing home resident so that the usual care giver can rest.

RESTRAINT Any manual method or physical or mechanical device, material, or equipment attached to or near a resident's body that he/she cannot remove easily and which prevents freedom of movement or normal access to one's own body.

A chemical drug used for discipline or convenience and is not needed to treat medical symptoms.

For single copies, please call 1-800-MEDICARE (1-800-633-4227).

¿Necesita usted una copia en Español? Llame al 1-800-633-4227.

If you use a TTY/TDD, please call 1-877-486-2048.

This publication is also available in Braille and Audiocassette.

This publication is also on the Internet at HCFA's web site address, **www.medicare.gov.**

Medicare & You
The knowledge to make good decisions

Do You Need Help to Pay Health Care Costs?

Where may I get help to pay health care costs?

Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who are entitled to Medicare and have a low income. You must have Medicare Hospital Insurance (Part A). If you are not sure if you have Part A, look on your Medicare card (red, white, and blue card). It will show "Hospital Insurance (Part A)" on the lower left corner of the card. You can also call your local Social Security Administration office, or call SSA at 1-800-772-1213.

If you have Part A, your income is limited (see below), and your financial resources such as bank accounts, stocks, and bonds are not more than $4,000 for an individual, or $6,000 for a couple, you may qualify for assistance as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI).

For more information about these programs, call your State, county, or local medical assistance office. Check your phone directory for the office nearest you. You can find these offices listed under Medicaid, Social Services, Medical Assistance, Public Assistance, Human Services, or Community Services. You may also call Medicare at 1-800-MEDICAR(E) (1-800-633-4227) (TTY: 1-877-486-2048 for the hearing impaired) to find the phone number in your State.

1999 Monthly Income Limit*

	Individual	Couple	Program Pays Medicare's...
QMB	$707	$942	Premiums, deductibles, and coinsurance
SLMB	$844	$1,126	Monthly Part B premiums
QI-1	$947	$1,265	Monthly Part B premiums
QI-2	$1,222	$1,633	A small part of the monthly Part B premium

*Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will change slightly in 2000, and new limits will be available by April 1, 2000.

Do you or someone you know have children under age 19 that are not covered by health insurance? There is help! A new Children's Health Insurance Program is available in your State. To find out how to qualify for the program, you can call the national toll-free number at 1-877-KIDS-NOW (1-877-543-7669). This number will automatically connect you to your State's insurance program for children.

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Publication No. HCFA–10118
Revised May 1999

Medicare & You
The knowledge to make good decisions

Medicare Preventive Services...

...To Help Keep You Healthy

There are steps you can take to lower your risk of disease and illness. Medicare is providing coverage for these preventive services to help you stay healthy. Medicare will cover:

- Tests for breast cancer, cervical cancer, vaginal cancer, and colorectal cancer;
- Bone mass measurements;
- Diabetes monitoring and diabetes self-management; and
- Flu, pneumonia, and Hepatitis B shots.
- Starting January 1, 2000, Medicare coverage for prostate cancer screening; includes digital rectal exam and Prostate Specific Antigen (PSA) test once every year.

These new, valuable benefits from Medicare may be the key to long lasting good health. Talk with your doctor about your risk of developing these health problems and your need for these preventive services.

This pamphlet includes:

- A chart that explains which preventive services are covered by Medicare, for whom they are covered, and what you pay.
- Cards with more detailed information on some of the preventive benefits. You can tear these out and put them on your calendar or refrigerator as a reminder, or you can take them to your doctor so that you can talk about the preventive services that Medicare covers.

Publication # HCFA-10110
Revised May 1999

Medicare Preventive Services — Added Benefits to Help You Stay Healthy

Covered Service	Who Is Covered	What You Pay
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare approved amount after the yearly Part B deductible.
Colorectal Cancer Screening: **Fecal Occult Blood Test** Once every year. **Flexible Sigmoidoscopy** Once every four years. **Colonoscopy** Once every two years if you are high risk for cancer of the colon. **Barium Enema** Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare approved amount after the yearly Part B deductible.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare approved amount after the yearly Part B deductible.
Mammogram Screening: Once every year.	All women with Medicare age 40 and older.	20% of the Medicare approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once every year if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding three years.	All women with Medicare.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare approved amount with no Part B deductible.
Vaccinations: **Flu Shot** Once every year. **Pneumococcal Shot:** Once may be all you ever need — ask your doctor. **Hepatitis B Shot:** If you are at medium to high risk for hepatitis.	All people with Medicare.	No coinsurance and no Part B deductible for flu or pneumococcal shots if the doctor accepts the amount Medicare approves as payment in full (accepts assignment). For Hepatitis B shots, 20% of the Medicare approved amount after the Part B deductible.

Colorectal Cancer Screening

Which colorectal screening benefits are covered under Medicare?

Medicare covers:

- A screening fecal occult blood test (FOBT),
- Flexible sigmoidoscopy, and
- Screening colonoscopy.

The FOBT and the flexible sigmoidoscopy are considered to be general preventive screenings. However, if you are at high risk for colorectal cancer, Medicare will cover a screening colonoscopy. Medicare also covers a barium enema if your doctor decides that a barium enema should be performed instead of a flexible sigmoidoscopy or screening colonoscopy. *(over)*

Medicare Preventive Services

Mammography Screening

Which breast cancer screening benefits are covered under Medicare? How often are they covered?

Medicare will pay for a mammogram each year. Regular mammography screenings can save your life.

Who is eligible to receive a mammography screening?

All female Medicare beneficiaries aged 40 or older are eligible for mammography screenings every year. Medicare also pays for one mammography screening for female Medicare beneficiaries between ages 35 and 40. *(over)*

Call 1–800–4CANCER for more health information.

Medicare Preventive Services

Flu, Pneumonia, and Hepatitis B Vaccination

Which preventive vaccinations are covered by Medicare?

Flu shots, pneumonia shots, and Hepatitis B shots are covered by Medicare. Flu, pneumonia, and hepatitis can be life threatening to the elderly.

Who is eligible to receive the vaccinations?

All Medicare beneficiaries are eligible for flu shots and pneumonia shots. Hepatitis B shots are covered only for persons at risk for Hepatitis B, such as those with end-stage renal disease or hemophilia.

(over)

Medicare Preventive Services

Pap Smear and Pelvic Exams (Includes Clinical Breast Exam)

Does Medicare cover screenings to find cervical and vaginal cancers?

Medicare covers Pap smears and pelvic exams to check for cervical and vaginal cancers. In addition to the pelvic exam, a clinical breast exam is also covered to check for breast cancer.

Who is eligible to receive Pap smears and pelvic exams?

All female Medicare beneficiaries are eligible. *(over)*

Call 1–800–4CANCER for more health information.

Mammography Screening—*Continued*

Am I at high risk for breast cancer?

Simply getting older increases breast cancer risk. The older you are, the greater your chance of getting breast cancer. However, several factors that could place you at higher risk include:

- If you had breast cancer before;
- If you have a family history of breast cancer—that is, a mother, sister, daughter or two or more close relatives who had breast cancer; or
- If you had your first baby after the age of 30, or if you never have had a baby.

How do I get more information about breast cancer and mammography screening?

Discuss breast cancer risk or screening with your doctor, or call the National Cancer Institute's Cancer Information Service at 1–800–4–CANCER.

Colorectal Cancer Screening—*Continued*

Who is eligible to get a colorectal screening?

Beneficiaries aged 50 or older are eligible for colorectal screenings. However, in the case of colonoscopies, there is no age limit.

How often will Medicare cover colorectal exams?

A fecal occult blood test is covered once per year and a sigmoidoscopy once every 4 years. If you are at high risk for colorectal cancer, Medicare covers a colonoscopy or a barium enema every 2 years.

Who is at high risk for colorectal cancer?

After age 40, colorectal cancer risk increases with age and throughout life. Your risk is greater if you have a history of inflammatory bowel disease, colorectal cancer, or polyps. You are also at greater risk if you have a family history of colorectal cancer or polyps, or have certain hereditary syndromes.

Pap Smear and Pelvic Exams—*Continued*

How often will Medicare cover a Pap smear and pelvic exam?

A Pap smear and pelvic exam are covered by Medicare once every 3 years. However, if you are a woman of child bearing age and have had an abnormal Pap smear within 3 years, or you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap smear and pelvic exam every year.

Who is at high risk for cervical or vaginal cancer?

Risk for cervical cancer is increased if you have had an abnormal Pap test, if you have had cancer before, or if you have been infected with the human papilloma viruses (HPVs). If you began having sexual intercourse before the age of 16, or if you have had many sexual partners, you also have a greater cervical cancer risk. Risk for vaginal cancer is increased for daughters of women who took DES during pregnancy.

Flu, Pneumonia and Hepatitis B Vaccinations—*Continued*

How often will Medicare cover these vaccinations?

Medicare pays for a flu shot every year. You should get one each year between October and December. Medicare will also pay for a pneumonia shot, which you should get by age 65. Most people only need to get this shot once in their lifetime. Medicare will pay for a Hepatitis B shot if you are at high or intermediate risk for Hepatitis B.

Who is at risk for flu, pneumonia, or Hepatitis B?

Flu and pneumonia infections can be life-threatening for elderly people. All adults 65 and older should get flu and pneumonia shots. Those at high or intermediate risk for Hepatitis B include individuals with end-stage renal disease or hemophilia.

Medicare & You

The knowledge to make good decisions

Medicare

Worksheet for Comparing Medicare Health Plans

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Congress created the Medicare + Choice program to let more private insurance companies offer coverage to people in Medicare. If you live in an area served by Medicare managed care plans, you may have choices in how you get your health care.

You may have heard about Medicare Medical Savings Accounts (MSAs) and Private Fee-for-Service (PFFS) plans. At the time this book was printed, no private insurance companies had decided to offer MSAs or PFFS plans to people with Medicare. To find out if these plans have become available in your area or to get pamphlets about these plans, call 1-800-MEDICAR(E)(1-800-633-4227).

Medicare managed care plans may have differences among them, such as cost, choice of providers, extra benefits, quality, paperwork, complaints, and convenience. Use this worksheet to ask the questions that are important to you and compare the answers. The information you gather will help you compare plans and make the health plan choice that is right for you. Write in the plan names and the answers from each plan to keep a record.

Each worksheet section begins with important information about the differences between the Original Medicare Plan and Medicare managed care plans.

You can get up-to-date information about the Medicare health plans available in your area:

- On the Internet at **www.medicare.gov**. Your local library or senior center may be able to help you find this information on their computers.

- By calling 1-800-MEDICAR(E) (1-800-633-4227) (TTY: 1-877-486-2048 for the hearing impaired).

- By calling the State Health Insurance Assistance Program (SHIP) in your area. The number for your SHIP will be listed in your copy of *Medicare & You* (which beneficiaries received in November of 1998), or can be found on the Internet at **www.medicare.gov**.

In all Medicare managed care plans, and the Original Medicare Plan, you must pay the monthly Part B premium.

In the Original Medicare Plan, you must pay additional costs such as hospital deductibles and coinsurance. The Original Medicare Plan does not pay for prescription drugs. You may be able to cover these out-of-pocket costs by purchasing a Supplemental Insurance Policy or by joining one of the other Medicare health plans. The additional costs in Medicare managed care plans depend on the plan's monthly premium (if any), copayments, and whether providers are allowed to bill extra. Costs vary from plan to plan.

In some Medicare managed care plans, you must get all covered services from doctors and hospitals that belong to the plan. **If you are in one of these plans, you may get services from doctors or hospitals outside your Medicare health plan, but you will be responsible for paying for these services. The exception is an emergency, or when you require urgently needed care and are out of the health plan's service area.**

Write the plan names in the blocks below.

Call the Plan. Does the plan...	Plan:	Plan:	Plan:
Charge a premium in addition to the Medicare Part B premium?			
Charge copayments for doctor visits?			
Pay for prescriptions? How much?			
Charge more if I use a doctor or hospital outside the plan? How much?			
Have maximum amounts it will pay for different services?			
Set limits on what doctors and hospitals charge you?			
Charge a deductible or coinsurance for inpatient hospital services, home health, or skilled nursing facility services?			

In the Original Medicare Plan and the Original Medicare Plan with a Supplemental Insurance Policy, you may use any provider who accepts Medicare. Many Medicare managed care plans require that you use the plan's doctors, hospitals, and other health care providers. They also may require a referral from your primary care doctor to see a specialist. Some allow you to visit certain specialists within the plan—like optometrists, gynecologists, or psychiatrists—without a referral. If you like your current doctor, first ask if he or she belongs to any of the plans you are considering.

Call the plan, and ask...	Plan:	Plan:	Plan:
Are my doctors in the plan?			
Is there a selection of the doctors, health professionals, and hospitals that I might need?			
Can I get the doctor I want? Is he/she accepting new patients under that plan?			
Can I see the same doctor on most visits?			
Can I change doctors once I am in the plan?			
What's the plan's policy if it does not have the type of specialist I need?			

Paperwork

For most services, Medicare managed care plans do not require you to file a claim form. With the Original Medicare Plan, and the Original Medicare Plan with a Supplemental Insurance Policy, you may have more paperwork. You may have to pay for covered services when you receive them, and then wait to be reimbursed.

Call the plan, and ask...	Plan:	Plan:	Plan:
Do I have to file claims myself?			

The types of services described in this section are in addition to services that are part of the covered services provided in the Original Medicare Plan. Supplemental Insurance Policies and Medicare managed care plans, often provide benefits not provided under the Original Medicare Plan.

Call the plan. Does the plan cover/provide...	Plan:	Plan:	Plan:
Routine physicals?			
Eye exams, glasses, contacts?			
Hearing exams and hearing aids?			
Dental exams/treatments?			
Programs that focus on helping members with specific, chronic conditions such as asthma, diabetes, or heart conditions?			
Programs that address needs like respite care, care giver services, and other social services?			
Wellness programs and classes that help you lose weight, eat properly, stop smoking, or exercise appropriately? Is there any charge?			
Other benefits you may be interested in:			

Generally, the Original Medicare Plan does not cover prescription drugs. Some Supplemental Insurance Policies help with the cost of prescription drugs, and some Medicare managed care plans may cover some of the cost for prescription drugs.

Call the plan, and ask...	Plan:	Plan:	Plan:
Does the plan cover the drugs I use?			
May I use my regular pharmacy?			
Are mail-order pharmacies available?			
What is the annual or quarterly dollar limit on prescription drug coverage?			
Will I have to pay more if I prefer to use brand name instead of generic drugs?			
Is there a maximum out-of-pocket cost for prescription drugs? What is it?			
Does the plan limit the drugs it pays for to those on a list of drugs (called a formulary)?			

Convenience

Location, hours of operation, and similar details, may be important to you. Contact each plan to decide if it is convenient for you.

Call the plan, and find out...	Plan:	Plan:	Plan:
Are the hours and location of its doctors, clinics and other health care providers convenient?			
Is my access to emergency care convenient?			
Are the doctors' offices, labs, and other services convenient?			
How fast can I be seen for urgent (non-emergency) care?			
Is there a telephone hotline for medical advice?			

All Medicare doctors must be licensed in their State. Medicare certifies hospitals, nursing homes, and suppliers. Medicare also requires that Medicare managed care plans establish quality assurance programs to get a Medicare contract. Once operating, Medicare managed care plans must meet standards set by State and Federal governments.

Beyond these basic standards, the quality of care in plans may vary. Three main types of information will tell you about the quality of care in a Medicare managed care plan.

1) Accreditation. This is an additional seal of approval by a private independent non-profit group, which evaluates a plan and gives it an official status based on that evaluation. Organizations that accredit Medicare managed care plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the American Accreditation Healthcare Commission.

2) Satisfaction surveys. These surveys ask beneficiaries how well they believe a plan meets their needs.

3) Performance measures. These are special reports that describe the provision of care, such as whether a plan regularly provides mammograms for women. Some of these reports are be available on the Internet at www.medicare.gov.

Ask...	Plan:	Plan:	Plan:
The plan: Is the plan accredited by an independent group?			
Your friends and relatives: Do they like the plan? Do they get the care they need, when they need it?			
Where available: How does the plan compare on performance measures and consumer satisfaction surveys? (You can get some of this information on the Internet at www.medicare.gov in late 1998.)			

You have a right to appeal many decisions concerning your Medicare benefits. In the Original Medicare Plan you are entitled to an appeal if you believe that Medicare should have paid, in whole or in part, for health care services or items you received. In addition, Medicare has a contract with local Peer Review Organizations to take your complaints about such things as quality of care and to resolve disputes if you believe that you are being discharged from a hospital before you feel well enough to go home.

Medicare managed care plans must have a process for resolving your complaints in a timely manner. Your Medicare health plan must provide you with written instructions on how to file an appeal when you feel you are wrongfully being denied care. After you file an appeal, the health plan must review its internal decision to deny care. Ultimately, if your health plan does not decide in your favor, your appeal automatically goes to an independent review organization that contracts with Medicare. If your health could be seriously harmed by waiting the amount of time needed for a standard decision, special rules apply and you are entitled to a decision within 72 hours.

Call the plan, and ask...	Plan:	Plan:	Plan:
If the plan has a patient advocate/ ombudsman to assist members?			
What is the plan's record regarding complaints?			

Other Questions You May Wish to Ask

Write Your Questions Here:	Plan:	Plan:	Plan:

Benefit Period—Starts the day you are admitted to a hospital or skilled nursing facility (SNF) and ends when you haven't received hospital inpatient or SNF care for 60 consecutive days.

Coinsurance—The percent of the approved charge that you have to pay either after you pay the Part A deductible, or after you pay the first $100 deductible each year for Part B.

Deductible—The amount you must pay before Medicare begins to pay either each benefit period for Part A, or each year for Part B.

Managed Care Plans—Managed care plans involve a group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. They include Health Maintenance Organizations (HMOs), HMOs with Point of Service Options, Provider Sponsored Organizations, and Preferred Provider Organizations.

Medical Emergency—Includes severe pain, an injury, sudden illness, or suddenly worsening illness that **you believe** may cause serious danger to your health if you do not get immediate medical care.

Medicare Medical Savings Account Plan—A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Policy with a high deductible. The other part is a special savings account, called a Medicare MSA. Medicare deposits money into the account to help pay your medical bills. Medicare also pays the premium for the health policy.

Original Medicare Plan—The traditional pay-per-visit arrangement that covers Part A and Part B services.

Peer Review Organizations (PROs)—Groups of practicing doctors and other health care professionals paid by the federal government to monitor the care given to Medicare patients. They are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; Medicare managed care plans and ambulatory surgical centers.

Primary Care Doctor—In many Medicare managed care plans, they coordinate and provide most or all of your health care.

Private Fee-for-Service Plan—A private insurance plan that accepts Medicare beneficiaries.

Referral—Permission from your primary care doctor to see a certain specialist or receive certain services.

Supplemental Insurance Policy—Many private insurance companies sell Medicare Supplemental Insurance Policies that fill the "gaps" in Original Medicare Plan coverage. Similar coverage may also be available to retirees through an employer or union health plan.

Urgently Needed Care—Unexpected illness or injury that needs immediate medical attention, but is not life threatening.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

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Medicare & You
The knowledge to make good decisions

Online at www.medicare.gov

The Official U.S. Government Site for Medicare Information

Established by the Health Care Financing Administration (HCFA)

HCFA's website has useful information for Medicare beneficiaries and those involved in helping them with their health care decisions. The main topics are:

- **"What is Medicare":** Medicare information, including eligibility and enrollment, and how to read a Medicare Summary Notice.
- **"Medicare Health Plans":** Medicare health plan options and educational materials. (Visitors can access "Medicare Compare" from this page to get information about health plans in their area.)
- **"Who to Contact":** information by State on the organizations that can help answer Medicare related questions.
- **"Publications":** Medicare publications in English and Spanish available to view, download, and print.
- **"Wellness":** information on Medicare prevention benefits to help keep you healthy, and facts about health issues such as peptic ulcers, and pneumonia.
- **"Fraud and Abuse":** how to identify and avoid common abuses of Medicare.
- **"Nursing Homes":** payment, patient rights, and nursing home survey results. (Visitors can access the "Nursing Home Compare" database from this page.)

"Medicare Compare" is HCFA's electronic database of health plan comparison information. The database is designed to educate beneficiaries and others about their health care options so they can make informed health care choices. The information is compiled by HCFA with cooperation from Medicare health plans and will be updated on a quarterly basis.

"Medicare Compare" includes:

- **Toll free telephone numbers** and website addresses for health plans.
- **Service areas** listed by State, zipcode, and county so beneficiaries can compare services in their own geographic areas.
- **Benefit and service packages** offered by each plan

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including detailed information on premiums, copayments, deductibles, and more.

- **"Helpful Hints"** to help users navigate within the database.
- **Guest book/E-mail** link back to HCFA for users' comments, questions, and suggestions.

The Health Care Financing Administration's Medicare Comparison Databases

How "Medicare Compare" works:

Users can choose the level of detail they want to know about the plans, searching either by State, county, or zipcode. While the database contains a broad range of information on the plans, all areas of interest to Medicare beneficiaries may not be included. HCFA will update the database quarterly to provide users with the most up-to-date and complete information.

In addition to looking at the list of Medicare health plans in a State, county, or zipcode, users can:

- Display side-by-side comparisons of services offered by two health plans.
- Search for a specific type of service such as vision care, podiatry care, or Pap tests.

"Nursing Home Compare" contains the following features:

- Information and survey data on every Medicare and Medicaid-certified nursing home in the country.
- Nursing homes listed by State, county, or name so beneficiaries can compare nursing homes in their own geographic area.

Seniors Surf the NET

More and more Medicare beneficiaries and those who will soon be eligible for Medicare use the Internet.

- According to Packard Bell NEC Inc., customers over age 55 accounted for 14 percent of retail purchases of its personal computers in 1997.
- AARP reports that in 1997, 36 percent of Americans between ages 50 and 64 owned a personal computer.
- 20% of surfers over 50 went on line at the urging of kids or grandkids; 53% said their main motivation was e-mailing family and friends, according to an online survey of more than 7,000 people in July and August by Third Age Media and The Excite Network.
- According to a 1997 report by Media Matrix Inc., men and women age 55+ spend an average of 117.8 minutes per day on the Internet.

While **www.medicare.gov**, **"Medicare Compare"** and **"Nursing Home Compare"** are designed especially for Medicare beneficiaries and the people involved in their health care decisions, anyone with access to the Internet can use it. Information in the database may be customized and printed for local and individual needs.

Other primary users will include:

- Beneficiary advocacy groups
- Social and case workers
- State Health Insurance Assistance Program staff and volunteers
- Staff in the National Association of Area Agencies on Aging network
- Federal and State organizations
- Health care providers

NMEP Regional Office Contacts
Updated August 1999

Region	NMEP Lead	Alternate	Fax
Region I - Boston Maine, Connecticut, Massachusetts, New Hampshire, Rhode Island, Vermont	Craig Schneider 617-565-1189	Marva Nathan 617-565-1234	617-565-3856
Region II - New York New York, New Jersey, Puerto Rico, Virgin Islands	Reginald Slaten 212-264-1122	Robin Thomas-Naarden 212-264-3660	212-264-2665
Region III - Philadelphia Delaware, Pennsylvania, Maryland, District of Columbia, Virginia, West Virginia	Peter Goodman 215-861-4213	Patricia Antrobus 215-861-4325	215-861-4176
Region IV - Atlanta Alabama, North Carolina, South Carolina, Georgia, Florida, Kentucky, Mississippi, Tennessee	Teresa Wilson 404-562-7235	Mike Pierson 404-562-7203	404-562-7255
Region V - Chicago Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Druecilla Brown 312-353-9845	Rita Wilson 312-886-5213	312-886-5705
Region VI - Dallas Arkansas, Louisana, New Mexico, Oklahoma, Texas	Susan McLaughlin 214-767-6487	Magda Flores 214-767-3018	214-767-0323
Region VII - Kansas City Iowa, Kansas, Missouri, Nebrasa	Darcy Jakopchek 816-426-6317 x3407	Denise Buenning 816-426-6317 x3419	816-426-3760
Region VIII - Denver Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Diane Kocher 303-844-7057	Lisa Gaglia-Blyle 303-844-7168	303-844-3753
Region IX - San Francisco American Samoa, Arizona, California, Guam, Hawaii, Nevada	Henry Tyson 415-744-3434	Neil Merino 415-744-3652	415-744-3761
Region X - Seattle Alaska, Idaho, Oregon, Washington	Sharrion Jones 206-615-2368	Stephanie Novacek 206-615-2406	206-615-2363

WORKING TOGETHER — IDEAS FOR THE FUTURE
POSSIBLE HEALTH CARE FINANCING ADMINISTRATION (HCFA) - LIBRARY PROJECTS/ACTIVITIES

CREATE A SENIOR INFORMATION CORNER

- Libraries could designate an area with relevant Medicare resource and referral information.
- HCFA could provide videos for display of Medicare and other related topics.

HOST A MEDICARE AND YOU DAY

- HCFA Regional office staff could conduct Health and Information Fairs.
- HCFA could coordinate library programs with local staff of the American Association of Retired Persons and the State Health Insurance Advisory Program and other partners.

HIGHLIGHT MEDICARE IN LIBRARY NEWSLETTERS

- Regional Office Medicare Team could submit copy to library each month for inclusion in the library newsletter or other publications.

SPONSOR A MEDICARE MONDAY

- HCFA staff could provide Medicare information to libraries so that the library can sponsor a "Medicare Monday" each month to keep patrons apprised of health care options available to them.
- HCFA might video tape a personal opening message and send supplementary handouts for library staff use.

INCREASE INTERNET ACCESS TO WWW.MEDICARE.GOV WEBSITE

- Regional Office Medicare Team could participate in regular "Navigate The Internet" sessions for elderly and disabled library patrons.

ELDER PROGRAMS

- HCFA Regional staff could conduct Elder Programs in the library, e.g. Medicare 101, Medicare & You, Fraud and Abuse, Medicare + Choice.
- Fact sheets could be provided on a number of topics, e.g., Who is HCFA, What is Medicare, Enrollment, Supplemental insurance, etc., that patrons could take home with them.

INTERGENERATIONAL MEDICARE ACTIVITIES

- HCFA Regional office staff could assist librarians in organizing intergenerational Medicare activities, e.g., youth from local community programs (Scouts, 4-H, etc.) could introduce grandparents and other seniors to the internet and ultimately how to get to www.medicare.gov.

If you would like to set up a program in your library, please contact the HCFA NMEP Regional Office Contact for your area. The contacts are listed under the resource tab.

Top 20 Medicare/Medicaid Questions and Answers

The following 20 questions and answers are the most frequently asked questions by callers to the Medicare + Choice toll free line for the time period from June 1 through June 30, 1999. These questions and answers will be updated monthly. Additionally, we have added other important questions at the bottom of this list.

1. How, when and where do I sign up for Medicare when I turn 65?

If you are already getting Social Security or Railroad Retirement checks when you turn 65, you will automatically be enrolled in Medicare. Your Medicare card (a red, white and blue card) will automatically be mailed to you about three months before your 65th birthday as part of your enrollement information package.

However, if you are not yet receiving Social Security or Railroad Retirement benefits, when you turn 65, you will need to contact your local Social Security Office. You will need to file your application during your 7-month enrollment period. That period starts three months before you turn 65 and ends three months after.

2. I didn't enroll in Medicare Part B when I turned 65 because I was still working. Can I enroll now?

If you didn't enroll in Medicare Part B during the initial enrollement period, you can enroll during one of two time periods.

The General Enrollment Period from January through March of each year. You will be entitled to Medicare Part B effective July 1 of that year. If you have waited to enroll in Medicare Part B, the monthly premium that you pay will go up by 10% for each year that you could have had Medicare Part B but did not sign up.

If you did not enroll in Medicare Part B because you were covered by an employer group health plan at the time you became eligible, you can enroll during any month that you are still in the plan. In that case, your Part B coverage will begin the first day of the month after you leave the health plan, up to 3 months after your enrollment in Part B. If you wait until leaving your employer's health plan to enroll, you can enroll up to 8 months after the end of the month you leave the plan. Your Part B coverage will begin the first day of the next month.

3. How do I know if I am eligible for both Part A and Part B?

You should contact your local Social Security office. The staff there can tell you if you are eligible for Part A and Part B.

4. Who is eligible for Medicare Part A?

Almost everyone who is 65 is eligible for Medicare Part A (Hospital Insurance). You may also be eligible if you are under 65 and have been receiving Social Security Disability benefits for 24 months. You should contact your local Social Security office for more specific information about your eligibility and enrollment for Part A.

5. What coverage is available for prescription drugs?

Generally, Original Medicare does not cover prescriptions. There are certain limited exceptions, like some cancer drugs. However, some Medicare managed care plans do cover drugs. In addition, if you are in the Original Medicare plan, Medigap or other supplemental insurance plans may cover drugs.

6. What types of services are covered under Medicare Part A and Part B?

Medicare Part A covers a variety of services including:

- Hospital Stays
- Home Health Care Hospice Care
- Skilled Nursing Facility Care

Medicare Part B covers a variety of services including:

- Doctor Services
- Laboratory Tests
- Outpatient Hospital Services
- Medical Equipment
- Blood Home Health Care

Part B also covers some preventive services such as mammograms and flu shots. (For more information on these services please see the Wellness Section of this site).

7. What does the Original Medicare Part B Plan not pay for?

Although Medicare helps with health care costs, it does not pay for everything. You are responsible for deductibles and coinsurance. Generally, the Original Medicare Plan does not cover outpatient prescription drugs. It also generally does not cover:

- routine physical examinations
- eye glasses
- custodial care dental care
- dentures
- routine foot care
- hearing aids
- orthopedic shoes

8. What diabetic supplies does Original Medicare cover?

Medicare covers the following supplies for both insulin and non-insulin dependent diabetics:

- Glucose testing monitor
- Blood glucose test reagent strips
- Lancets Glucose control solutions
- Spring powered devices for lancets

Some frequency limitations may apply. Medicare does not cover insulin and syringes.

9. What do I have to pay for Home Health Care?

Generally, you pay nothing for Home Health Care services and 20% of the Medicare approved amount for any durable medical equipment you need.

Some examples of covered services include; part-time and intermittent skilled nursing care, Home Health aid services, medical supplies such as wound dressings, physical and occupational therapy.

Medicare does not pay for the following services given in the home; 24 hour nursing care, meals, prescription drugs, and homemaker services such as shopping, cleaning and laundry.

You should contact your Regional Home Health Intermediary, who can be found on this site under Important Contacts, for more specific information.

10. Does it cost me anything to have a mammogram?

It depends on your Medicare health plan. If you are in the Original Medicare Plan, you can get a mammogram once a year when you are 40 or older. You don't have to pay the Part B deductible for this test, but you will have to pay your regular 20% coinsurance.

If you are in a Medicare managed care plan, your plan may cover even more than this for your mammogram. You should call your plan to find out more about this benefit.

11. How can I get a replacement Medicare card?

You should contact your local Social Security Office to get a replacement card.

12. I can not afford my Medicare premiums. What can I do?

If your income is limited, your State may help you pay your Medicare costs, such as your premiums and deductibles. Check the Important Contacts section of this web site for the phone number of your State medical assistance office. They can help you determine if you qualify for help.

13. What is available to help me pay for medical costs not covered by Original Medicare?

To help pay for services and costs that Medicare does not cover, many people buy supplemental insurance policies. Medicare supplemental insurance policies are standardized private insurance policies that fill gaps in the Original Medicare plan. These policies pay some of the costs that the Original Medicare Plan does not pay. You can get more information on supplemental insurance policies by contacting your State Health Insurance Assistance Program. The number of the State Health Insurance Assistance Program in your area may be found in the Important Contacts section of this web site.

14. What is Medicaid and who does it cover?

Medicaid is a health insurance program for certain low-income people. It covers children, the aged, blind, disabled, and people who are eligible to receive other federal assistance. In some cases, Medicaid will help pay for Medicare premiums, deductibles, and coinsurance. For more information, you can contact your State medical assistance office. You can find the State medical assistance office telephone number by going to the Important Contacts section of this site.

15. What managed care plans are available in my area?

The Original Medicare plan, the traditional fee-for-service system, is available nationally and Medicare managed care plans are available in many parts of the country. You can search for plans in your area using the Medicare Compare feature on this web site.

16. What is Medicare+Choice (or Medicare Health Plan Choices)?

Medicare+Choice expands the Medicare health plan options to include a broader range of plans. Currently, the types of Medicare+Choice plans that are available are the Original Medicare Plan and Medicare managed care plans. Other types of plans such as Private Fee-For-Service Plans and Medicare Medical Savings Accounts may become available in the future.

17. What if there are no Medicare managed care plans in my area? What are my options?

Medicare managed care plans are set up by insurance companies. These companies are independent businesses that make business decisions on the types of health plans they will offer. If there are no managed care plans in your area, you still have Original Medicare coverage. Other options include supplemental insurance such as Medigap. And, you might be eligible for Medicaid coverage if you meet certain income requirements. Your State Health Insurance Assistance Program can discuss these options with you further.

18. Where can I find information about plans in my area?

You can find this information by checking the Medicare Compare section of this website for a listing of health plan benefits and quality information. You can also get this information mailed to you by calling 1-800-MEDICARE (1-800-633-4227).

19. What plan is best for me? Can you recommend a plan?

Medicare can not recommend a plan to you. However, a comparison of plans in your area is available on this site or by calling 1-800-MEDICARE (1-800-633-4227). Any decision about your health care is an important one. You may want to talk with people you trust about which plan would best meet your needs.

20. What are supplemental insurance policies or Medigap?

Supplemental Insurance policies are sometimes called Medigap plans. Medigap plans are private health insurance policies that cover some of the costs the Original Medicare Plan does not. Some Medigap policies will cover services not covered by Medicare such as prescription drugs. In most States, a Medigap plan must be one of 10 standard plans called Plans A through J.

Other Important Questions

1. How does the Original Medicare Plan work?

The Original Medicare Plan is the traditional fee-for-service system that covers your health care needs. The Original Medicare Plan has two parts, Part A for hospital services and Part B for medical services. Medicare pays its share of the bill and you pay your share. You may choose to go to any doctor, hospital, or other health care provider, like a home health agency, which accepts Medicare payment.

2. Will I be responsible for sending my claim to Medicaid?

No, under the Original Medicare Plan your claims are sent to your state Medicaid program for you. Sometimes your provider (hospital or physician) will send the claim to Medicaid after they receive the notification of what Medicare paid. Other times the contractor that pays your Medicare claim will send it to Medicaid.

In an effort to get more feedback to improve future Medicare & You handbooks, we will be placing a feedback postcard for beneficiaries to complete and mail back inside a selected sample of the Medicare & You 2000 handbooks. A copy of the postcard survey is attached for your reference. As a result of this mailing, you may receive some questions from beneficiaries. Below are some common questions you might expect and answers to assist you in responding to beneficiary inquiries related to this feedback postcard.

Why is this postcard in my handbook?

The Federal Medicare Agency, HCFA, wants to make sure that the handbook is a good, easy to read, information tool. HCFA chose to put a feedback postcard in a number of handbooks to make it easy for you to tell us how well we are doing. Your comments will help HCFA to improve the handbook in the future.

How many total postcards are there in handbooks this year?

Ten out of 26 versions of Medicare & You 2000 mailed-in Fall 1999 contain this feedback postcard, for a total of 16.8 million postcards.

Is it really a government survey? What is HCFA?

Yes. This survey is being done by the Health Care Financing Administration, or HCFA. HCFA is the Federal Medicare Agency.

Why are there only two questions asked and not others?

We wanted to use a postcard to make it easy for you to mail back. It also costs less than a letter. The size of the postcard means we only have room for a few questions. We chose the two questions that we thought might be the most important to people who use this handbook. You also can write any other comments about the handbook you feel are important on the postcard.

How will this information be used?

Comments and answers to the questions will be used for revising and improving future Medicare & You handbooks.

Is my response confidential?

The reply postcard contains no identifying information about you. We have separated the postcards by census areas only. It will be impossible to tell who sends back the postcard. Your response will be confidential.

I have more comments about Medicare & You than fit on this form. What do I do?

You may mail your comments to HCFA in a letter using the address on the front of the postcard. If you have a computer, and can visit the www.medicare.gov website, you can send your comments electronically on a bounceback card that is with the Internet version of Medicare & You 2000. If you have a computer with e-mail, you can send your comments to comments@hcfa.gov. If you don't have a computer, your local library or senior center maybe able to help you access the Medicare website.

The disclaimer (small print) says that no one is required to respond to this survey unless it has the control number. Since it has a number, do I have to fill it out?

No, filling out the postcard is voluntary. What the disclaimer (small print) means is that HCFA cannot mail this card to you and expect you to fill it out without this number on the form. In other words, it is not a legitimate survey without that number.

I have comments or suggestions about this form. Do I have to write to you or is there a number I can call?

There is no phone number available. You should put your comments or suggestions in writing, and send them to the following address: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

I have comments about other Medicare brochures. What do I do?

Write to HCFA, the Federal Medicare Agency, using the address on the postcard.

Where can you get the official word on today's Medicare?

Wherever you see this symbol.

Medicare & You

The knowledge to make good decisions

An education program of the Department of Health and Human Services
and the Health Care Financing Administration

www.medicare.gov

1-800-MEDICARE
(1-800-633-4227)

Use one of the small ads below to place in printed materials (e.g., newspapers, newsletters).

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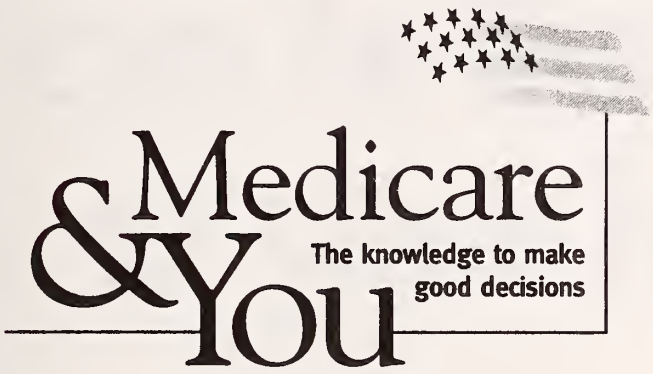

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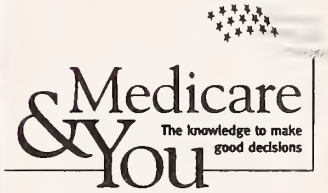

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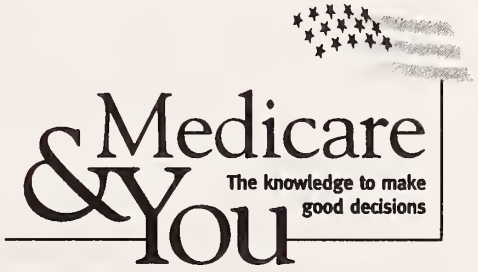
Learning about today's Medicare can be beneficial to your health.

Today's Medicare offers more.
More preventive benefits. More information.
More help with your questions.



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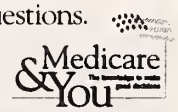

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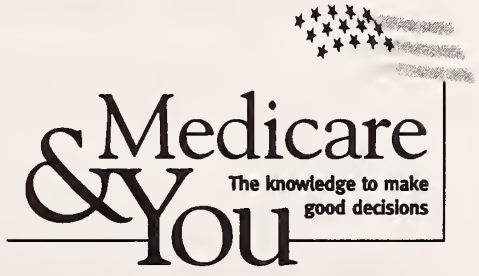

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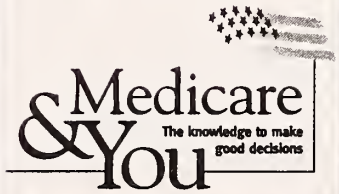

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1-800-MEDICARE
(1-800-633-4227)

Medicare Educational Materials Request Form

Title	Pub #	Quantity
Advance Directives* - How to prepare advance directives - English	**02175**	
Advance Directives - How to prepare advance directives - Spanish	**10949**	Available 10/99
Do You Need Help to Pay Health Care Costs?* - Help for people with low income (Medicaid) - English	**10118**	
Do You Need Help to Pay Health Care Costs? - Help for people with low income (Medicaid) - Spanish	**11015**	Available 8/99
Does Your Doctor or Supplier Accept Assignment?* - An explanation with examples of how Assignment can save you money in the Original Medicare Plan.	**10134**	Available 9/99
Guide to Choosing a Nursing Home* - Detailed information about how to choose a nursing home - English	**02174**	Available 9/99
Guide to Choosing a Nursing Home* - Detailed information about how to choose a nursing home - Spanish	**10972**	Available 10/99
1999 Guide to Health Insurance for People with Medicare - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance - English	**02110**	
1999 Guide to Health Insurance for People with Medicare - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance - Spanish		
1999 Guide to Health Insurance for People with Medicare - Comprehensive guide to Medicare Supplemental Health (Medigap) Insurance - English Large Print		
It's your life, know your number - Information about diabetes - English	**10924**	
It's your life, know your number - Information about diabetes -Spanish	**10933**	
Learning About Medicare Health Plans - Six Steps to Choosing a Health Plan* - Steps to follow when choosing your Medicare health plan.	**10114**	
Medicare & You 2000 - National version of Medicare's beneficiary handbook - English	**10050**	Available 10/99
Medicare & You 2000 - National version of Medicare's beneficiary handbook - Spanish	**10950**	Available 10/99
Medicare & You 2000 - National version of Medicare's beneficiary handbook - English - Large Print	**02139**	Available 10/99
Medicare & You 2000 - National version of Medicare's beneficiary handbook - Spanish - Large Print	**02140**	Available 10/99
Medicare Appeals and Grievances * - How to file an appeal or grievance if you have a complaint.	**10119**	
Medicare Coverage of Kidney Dialysis and Transplant Services - Information about Medicare coverage for those with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant - English	**10128**	
Medicare Fraud and Abuse - How to identify fraud and abuse, and how to protect yourself and the Medicare program.	**10111**	
Medicare Home Health - An explanation of Medicare's home health care coverage - English	**10969**	Available 9/99
Medicare Home Health - An explanation of Medicare's home health care coverage - Spanish	**10971**	Available 9/99
Medicare Hospice Benefits - An explanation of Medicare's hospice care coverage - English	**02154**	Available 9/99
Medicare Hospice Benefits - An explanation of Medicare's hospice care coverage - Spanish	**10951**	Available 9/99
Medicare Medical Saving Account Plan Brochure - Detailed information about Medicare Medical Savings Accounts.	**10106**	

Medicare Medical Savings Account Plan Offers You a New Option (Fact Sheet)* - A brief introduction to the new Medicare Medical Savings Account Plan option.	**10107**	
Medicare Patient Rights - Lists your rights as a Medicare beneficiary.	**10112**	
Medicare Preventive Services...To Keep You Healthy* - Descriptions of preventive services covered by Medicare, with handy tear-out reminder cards.	**10110**	
Medicare Private Fee-for-Service Plan Brochure - Detailed information about Medicare Private Fee-for-Service Plans - English		
Medicare Private Fee-for-Service Plan Brochure - Detailed information about Medicare Private Fee-for-Service Plans - Spanish		
Medicare Questions and Answers - Answers questions about the Original Medicare Plan, other Medicare health plans, and beneficiary rights and protections	**10117**	Available 8/99
Medicare Savings for Qualified Beneficiaries - Information on help paying health care costs - English	**02184**	
Medicare Savings for Qualified Beneficiaries - Information on help paying health care costs - Spanish	**10954**	
Medicare Supplemental Health Insurance (Medigap) Policies and Protections - Information about Medicare Supplemental Health Insurance (Medigap/Medicare SELECT) Policies and Protections. (Revision in progress. Previously called Medicare Supplemental Insurance Policies. Old version currently available.)	**10115**	Available 9/99
New Health Insurance Now Available for Infants, Children and Teens - Information on the Children's Health Insurance Program, a State program to help provide free health coverage for children in low-income families.	**10135**	Available 8/99
Nursing Homes - Basic Information on how to choose a nursing home.	**10121**	Available 8/99
Private Contracts with Doctors and Other Practitioners Who Have Decided Not to Provide Services Through the Medicare Program (Fact Sheet) - A brief explanation of Private Contracts.	**10109**	
Understanding Your Medicare Choices* - Brief description of Medicare health plan options.	**10120**	
Worksheet for Comparing Medicare Health Plans* - Worksheet that can be used to help you ask the right questions when comparing Medicare health plans.	**10113**	
www.medicare.gov- Overview of the consumer based HCFA Internet Site.	**10108**	
Your Medicare Benefits* - An explanation of what services are covered under Part A and Part B.	**10116**	

***Revised version to be available between 8/99 and 10/99.**

SHIPPING ADDRESS

Name of Organization:_____

Contact Person:_____ **Phone Number:**_____

Address (No P.O. Boxes):_____

City:_____ **State:**_____ **Zip Code:**_____

Special Shipping Instructions:_____

Fax this order form to 1-410-786-1905. Thank you.

*U.S. Government Printing Office: 1999 — 771-526

For general Medicare information read:

•*Medicare & You 2000*

•Medicare Preventive Services

•Medicare Worksheet for Comparing Health Plans

For information about Supplemental Health Insurance (Medigap) Policies read:

•1999 Guide to Health Insurance for People with Medicare

For information about Children's Health Insurance read:

•New health insurance now available for infants, children and teens

For information about Nursing Homes read:

•Guide to Choosing a Nursing Home

If you need help paying health insurances costs read:

•Medicare Savings for Qualified Individuals

For information about Medicare information on the internet read:

•www.Medicare.gov

To find out who to call for help read:

•Resources

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HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
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Baltimore, Maryland 21244-1850

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September 1999

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